Washington State Planning Grant on Access to Health Insurance

HRSA Interim Report

October 29, 2001

Making Health Care Work For Everyone

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WASHINGTON STATE
HRSA STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
INTERIM REPORT TO THE SECRETARY: OVERVIEW

EXECUTIVE SUMMARY

Washington State received its grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) effective March 2001. States were awarded these grants to assist them in profiling the uninsured and to research innovations in providing access to affordable health insurance coverage and adequate benefits, especially through expanded private/public partnerships.

Two products are required as a condition of the grant: Interim Report due October 2001 and Final Report due March 2002. This report meets the first of those requirements. It is primarily a progress report. We currently are immersed in the process of collecting and analyzing data, and in developing the foundation for determining coverage and access improvement strategies that may have future viability in Washington State.

The following sections include brief descriptions of: (1) the change in Washington's environment post award of the grant, (2) the benefits of receipt of the grant, (3) the balances and trade-offs in the focus of our work, and (4) a high level project overview.

Environment

In the short fifteen months since Washington submitted its grant proposal (July 2000), the context for our work has changed significantly. A State budget surplus has given way to a potential deficit of $1 billion for the current biennium (July 2001 – June 2003), with an equally fearful outlook for the 03-05 biennium. The spending and revenue limitations under which state government operates, the impacts of a drought and a transportation crisis, plus the passage of initiatives that ear-mark dollars for specific purposes (e.g., teacher pay raises) create unprecedented pressures on the state budget. Add to the picture the following challenges: (1) a general economic downturn including massive aerospace layoffs and uncertainty about consumer confidence (in a state that lives and dies by the sales tax), (2) a growing crisis in our health care delivery system including, for example, hospital workforce shortages and issues around recruitment and retention of physicians in various regions of the state and for certain lines of business, (3) a restructured but untested individual market from which the sickest are screened and referred to a more expensive high risk pool, (4) a public health and safety net system stretched to the maximum, and (5) increasing health care costs hitting both private and public purchasers and consumers.[1] (Although these challenges were already in place prior to September 11, the events and aftermath of that day will surely exacerbate them.)

Grant Benefits

Amid all of this, receipt of the HRSA grant has allowed the State to continue to be an active participant in the search for a more affordable health care system and one that is accessible by all. The grant is supporting work important to short- and long-term planning – work that if it

were happening at all would surely not be happening in the disciplined and rigorous manner allowed by this funding. For example, we are able to (1) provide solid research to help inform policy, program design, and business decisions about health care coverage and access, (2) investigate opportunities for the state to make it easier for private sector and other public sector entities to partner with it, (3) rigorously "mine" our data to better understand populations and systems –much of the data exist but resources are not always available to make maximum use of it, and (4) take advantage of deep and varied outside expertise and perspective.

Balances

There has been no shortage of opinions on where the efforts and resources of the grant should be focused, while remaining true to the proposal on which the grant was awarded. Below are examples of the push-pulls that we continue to balance as our work proceeds.

- *Expansion or maintenance?* In the short-term (the definition of which is now extending into 2005), the issue for Washington's public programs is not expansion -- in the best of worlds it is maintenance of past gains and in the worst of worlds it is minimization of deterioration. Nonetheless, ensuring access and coverage remain a state value and priority -- the questions are how, to whom, when, and who will pay. Similar issues extend to all levels of government, as well as to the private sector -- small business employees, individuals buying on their own, people referred to the high risk pool, and early retirees are among those at risk of no longer being able to afford the coverage they have had in the past.
- *Access to coverage or access to care?* Although access to affordable insurance coverage matters, it is by no means viewed universally as the primary issue. Even in the context of "adequate" benefits, the argument is that coverage does not ensure access to appropriate and effective care -- certainly for those without coverage but also for those with it. The question asked is: What has been achieved if the rate of un-insurance is reduced without addressing "real" access to care?
- *Incremental or transformative?* There has been much angst over our horizon of focus: targeted, short-term or global, future-shaping; respond to the evolving crises of the day or keep a broader focus. These various perspectives are not necessarily mutually exclusive and we are trying to achieve a balance that treads their common ground. For example, while we focus on doable next steps we put those steps in the context of future changes (e.g., in what populations are we likely to see increasing numbers of uninsured; what if a sea-change occurs among employers and their employees are let loose with defined contribution vouchers to purchase in Washington's individual market). Admittedly, the reality of "incremental transformation" in the absence of a common vision of the transformed future is a bit of a challenge.

Project Overview[2]

Washington is taking a very methodical approach to its work and believes that selecting improvement strategies in the absence of data, education, and dialogue will not be successful. Briefly our work consists of the following (plus see Appendix III for Guiding Principles for this project):

- Problem Definition -- Detailed profiles of the uninsured population are matched to detailed profiles of the current coverage and care pathways, followed by a rigorous analysis of the gaps, overlaps and barriers.

- Strategies Delineation -- Analysis of the strengths and weaknesses of a universe of potential coverage and access options is cross-walked to a similar analysis of parallel strategies historically tried or in place in Washington (including, where appropriate and achievable, quantifiable impacts of strategies on specific uninsured and at-risk populations).
- Linkage -- Detailed assessment is conducted of the links between identified gaps, overlaps, and barriers to coverage and care (in specific populations and circumstances) and the analysis of improvement strategies (including refinement of strategies based on linkage assessment).
- Individual Affordability -- Significant energy is devoted to understanding what individuals can afford to pay for coverage and care, compared to the reality of what's available to them. We consider this a "lynchpin" issue for crafting future coverage and access strategies.
- System Affordability -- Significant effort is focused on administrative simplification strategies and partnerships, including options for reducing the currently complex array of insurance products (while still maintaining choice and variety). Creating a more affordable system via strategies that avoid unnecessary costs, reduce provider administrative burden, and set the stage for effective consumer-driven buying is directly relevant to improving access.
- Community Partnerships -- Building partnerships with community-based efforts and organizations addressing related issues is also a focus of our work. Mutual understanding of the issues faced, the solutions contemplated, and the flexibilities and accountabilities needed on all sides are part of this work.
- Education and Input -- Sharing and seeking input into the process and substance of grant activities with a variety of constituent groups (e.g., community and business leaders, policy makers, residents, and industry leaders--providers, purchasers, payers, regulators) is a key goal, as is partnering with others in the state who are interested in both incremental and transformative strategies for improving access for all.

As stated earlier, we are deep into the data collection, analysis, and foundation-building phase of our work. As such our findings on profiles, policy options, lessons learned, and recommendations to States and for Federal action have not yet emerged. Our greatest challenges at this time are not surprising – they are time and attention. Engaging people as we all work around the crises of the day (whether they be health care or otherwise) is not easy or quick. Most eyes are on the current condition of the state budget and the potential for program cuts as well as other impacts on the state's health care delivery and financing systems. In this environment, it is almost beyond the pale to engage anyone in a discussion of expansion of coverage much less universal access. And thus is our challenge -- to think to the future without losing relevance to the present.

In the following sections we add more detail about our progress and process. Each section begins with a summary. Because this is our interim rather than final report, we generally do not have answers to specific questions. In the few cases where information is available, we have bolded the applicable question. (All questions from the report template have been retained – whether answered or not.)

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Methods: The in-depth profiles of uninsured individuals and families plus the mapping of current pathways for coverage and for access to safety-net-provided care set the stage for detailed analysis of gaps, overlaps and barriers to coverage and care. A special emphasis is being placed on understanding individual affordability. Major data sources consist of existing surveys (population-based and employer-based), a project-specific survey to gather information on benefit designs and costs, administrative data, and focus groups.

Findings: Findings to-date are sketchy and subject to change as analysis continues. Answers to Questions 1.1, 1.2, 1.3, and 1.4 provide a flavor of areas of focus, progress, and early findings (where applicable).

Progress:
(1) Potential data sources have been compiled, summarized, and analyzed for application to the grant's work (e.g., content analysis, support of local area estimates, and linkage of information across sources). (Information about reasons for differences in estimates across survey sources is already helping to allay suspicions about "the right numbers.")
(2) Analysis of data-needed versus data-available, and development of strategies for addressing data gaps continues (specifically in relation to matching profile information to possible strategies for coverage and access).
(3) Specific work focuses on supplementing the Washington State Population Survey (SPS) with the Survey of Income and Program Participation (SIPP); as well as creating baseline information to which routinely collected data (e.g., Medical Expenditure Survey) can be compared in the future. (Given the high cost of primary data collection and the state's desire for on-going monitoring, we have a strong interest in finding creative ways to use existing data that are routinely collected by others.)
(4) Review of other states' surveys is ongoing, as background for recommended improvements to Washington's biennial household survey.
(5) First cut profile results are beginning to show (see questions below); more complex, multi-dimensional analyses are underway.
(6) Coordination among state level experts (demographers and forecasters) and research experts continues as data issues arise (e.g., resolving a problem with the weights associated with children's counts in the Current Population Survey [CPS]).
(7) See Section 3 for progress on the affordability analysis.

Attached in Appendix III are draft documents related to the analysis of existing data sources: Bibliography for population and employer-based surveys, Overview of population-based surveys, Content analysis of population-based surveys, Overview of employer-based surveys, Content analysis of employer-based surveys, and Data sources for understanding pathways to coverage and care. Also included in Appendix III are Demographics of Washington State's uninsured population (see question 1.2) and the Private payer questionnaire (see question 1.4).

Relationship to Coverage Strategies: Our intent is to align the analyses noted above (i.e., profiles + mapping = gaps, overlaps, barriers analysis) with an equally rigorous analysis of

potential strategies (see Section 4), resulting in a tight link between proposed interventions and targeted populations. We are progressing on this front but have significant work yet to do.

1.1 What is the overall level of uninsurance in your State?

According to the Washington State Population Survey (our baseline source), 8.4 percent of Washingtonians were uninsured in 2000. For children 0-18 years of age, the uninsured rate was 7.2 percent; for adults ages 18-64 the uninsured rate was 10.2 percent. More than three times as many adults as children were uninsured in Washington in 2000.

1.2 What are the characteristics of the uninsured?

Preliminary information (subject to change) regarding the demographics of Washington State's uninsured population is provided in Appendix III. Early results by relevant dimensions (e.g., age, household income)[3] can be summarized as follows: Within select

a. Age groups -- the largest percent of uninsured are 19-24 years of age.
b. Household income groups -- the largest percent of uninsured are associated with annual household incomes of less than $14,999 (1999 dollars).
c. Regions of the state -- the largest percent of uninsured are in rural Eastern Washington.
d. Race/Ethnicities -- the largest percent of uninsured are identified as American Indian/Alaska Native and Hispanic.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

We did not decide this a priori; rather we are looking to the data to indicate where and with what populations various interventions might be most effective. We are approaching the profiling task in a variety of ways to determine which information is of most use in matching populations to strategies, e.g., (1) single-variable and multivariate profiling; (2) profiling by demographics, (3) profiling by coverage risk – long-term uninsured, periodic insurance, at high-risk of losing coverage, (4) profiling by work status – worker or live with worker versus not, etc. We are also working on an approach that "backs us into the target populations," i.e., array the potential universe of coverage and care strategies, map them onto the populations for which they are designed, and assess the degree to which those populations occur in Washington's uninsured. In other words, we are exploring a variety of options for understanding our uninsured population and where targeting of strategies may be most appropriate and effective.

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Although we have no findings to share at this time, affordability of coverage for individuals is a major focus of our work. Our starting point is *The Self-Sufficiency Standard for Washington State,* which assesses by county how much money it takes for families to live without public or private assistance or subsidies.[4] This information is being combined with data on price sensitivity and with grant-specific survey results on what it actually costs (all out of pocket costs) for various types of coverage in Washington (e.g., individual, small group, and large employer). The survey, Private

Payer Questionnaire, is attached in Appendix III (it is serving multiple purposes, one of which is related to the affordability analysis -- see Section 3).

Results on affordability will have applicability beyond the specifics of this grant period. For example, the Department of Social and Health Services is currently applying for a federal Medicaid waiver to provide flexibility in future design of its program. Design elements such as premium sharing and point-of-service cost sharing levels for certain populations were not directly addressed in the waiver but need to be developed in the future. We are working with the Medicaid program to ensure that our analysis will be applicable to their needs.

We are not prepared to answer the following questions at this time.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

1.6 Why do uninsured individuals and families disenroll from public programs?

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

1.9 How likely are individuals to be influenced by:
Availability of subsidies?:
Tax credits or other incentives?:

1.10 What other barriers besides affordability prevent the purchase of health insurance?

1.11 How are the uninsured getting their medical needs met?

1.12 What is a minimum benefit?

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Methods: In the mid 1990s (approximately 1993-1997) significant work occurred in Washington to understand the profiles of employers who offer and do not offer coverage, and their motivations. To build on that history, we are using focus groups, particularly of small employers. Timing of the focus groups is critical to their effectiveness in guiding our work. That is, we need to build the groups around information – information about the uninsured, individual and market affordability, and analysis of potential options for improving access that may call for employer participation. The hypothesis is that guided discussion in the context of relevant and specific information (compared to a context void of such data) will yield a greater return-on-investment in terms of understanding values, decision-drivers, and areas of ambivalence. Thus we planned that these groups would occur somewhat later in our process—after we have been able to develop the needed information through our profiling and analysis of options-for-access. As this analytic work unfolds, we may also decide that a focused survey of employers would be useful. In that case, we anticipate using the focus groups to help conceptualize and perhaps "pilot test" such a survey. (Clearly, actual fielding of such a survey would occur outside the initial grant-year period.)

Findings: There are no findings to report at this time.

Progress:
Much of this work is dependent upon completion of other work in the grant. However, the following have occurred:

(1) Existing employer-based surveys have been compiled, summarized, and analyzed for development of baseline information.
(2) Initial framing of the focus group protocol is occurring; as is preparation for review by the Institutional Review Board (i.e., human subjects review entity).
(3) See Section 3 for discussion of the Private Payer Questionnaire which is serving multiple purposes, one of which is to understand the scope of products available in the small group market.

Attached in Appendix III are the following: Overview of employer-based surveys, Content analysis of employer-based surveys, Private payer questionnaire.

Relationship to Coverage Strategies: As noted above, we did not start the grant work with pre-selected coverage strategies to pursue. We expect data, education, and input by potentially impacted parties to drive the process of strategy filtering. Understanding the pressures faced by, the trade-offs needed by, and the potential "tipping points" of employers is critical to this process.

We are not prepared to answer the following questions at this time.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?
Employer size (including self-employed):
Industry sector:

Employee income brackets:
Percentage of part-time and seasonal workers:
Geographic location:
Other(s):
For those employers offering coverage, please discuss the following:
Cost of policies:
Level of contribution:
Percentage of employees offered coverage who participate:

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

2.3 What criteria do offering employers use to define benefit and premium participation levels?

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

2.5 What employer and employee groups are most susceptible to crowd-out?

2.6 How likely are employers who do not offer coverage to be influenced by:
Expansion/development of purchasing alliances?:
Individual or employer subsidies?:
Additional tax incentives?:

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Methods: Washington's analysis of the marketplace focuses on four areas: (1) Pathways (options) that people currently have for coverage and access, and where the gaps and overlaps exist; (2) Variety and complexity of product offerings in the market (individual, small group, large group—fully insured and self-insured), and where opportunities exist for complexity reduction; (3) Affordability of coverage for individuals (healthy and sick, various income levels, different geographic regions, several family types, different industries), in light of actual income, income needed to achieve self-sufficiency, and cost of coverage; and, (4) Opportunities for reducing the burden of the administration of health care services, in partnership with the private sector. Secondary data from a variety of existing data sources are being used (e.g., research, industry, regulatory, and administrative databases). In addition, primary data collection is occurring through (a) a marketplace survey (including follow-up focus group and/or interviews) with select insurance carriers and third party administrators and (2) a structured interview protocol administered via telephone with informed experts.

Findings: Data are being collected and analyzed, however, findings are not yet available.

Progress:

(1) Pathways and Gaps, Overlaps, Barriers: Key indicators and data sources have been identified. Data collection regarding pathways is well in hand; analysis and verification of data are underway. Preliminary mapping of safety net resources has occurred.
(2) Product Offerings and Costs: The marketplace survey (Private Payer Questionnaire) is in the field. Pre-fielding telephone calls from the Governor's Health Policy Advisor to top officials of major carriers and third party administrators were made to brief them and request cooperation.
(3) Affordability: The measure of self-sufficiency has been selected. Recommendations regarding sources of data to generate estimates of actual family income are under review. Price sensitivity research is being incorporated into the methodology design.
(4) Administrative Simplification: Structured interviews with informed experts have been completed and results are under review.

Attached in Appendix III are the following: Data sources for understanding pathways to coverage and care (work-in-progress), Safety net map (work-in-progress), Administrative simplification interview protocol, and Private payer questionnaire (i.e., marketplace survey).

Relationship to Coverage Strategies: Findings from the above will either drive or be directly tied to the analysis of coverage and access strategies.

We are not prepared to answer the following questions at this time.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?
3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

3.6 How would universal coverage affect the financial status of health plans and providers?

3.7 How did the planning process take safety net providers into account?

3.8 How would utilization change with universal coverage?

3.9 Did you consider the experience of other States with regard to:
Expansions of public coverage?:
Public/private partnerships?:
Incentives for employers to offer coverage?:
Regulation of the marketplace?:

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Methods: There are four separate (but related) efforts that will contribute to developing improvement options or strategies for consideration. Each of these efforts is described below.

- *Coverage and Access*: This analysis focuses on the strategies traditionally identified as options for improving coverage and access, e.g., employer buy-ins to public programs. Here we are interested in rigorous analysis of the "universe of strategies", mapped to parallel approaches historically tried and/or currently in place in Washington State, and culminating in analysis of strengths and weaknesses, potential viability for implementation, and estimated impact on specific populations identified in the profile analysis (e.g., number of uninsured in a given population group impacted if this option were implemented.). The database of strategies is being developed via literature reviews, environmental scans of other states' experiences (state level and otherwise; public and private), and expert opinion. Analysis of options along specified dimensions, estimation of quantitative impacts (where possible), and use of decision criteria for "moving" ideas forward are also part of the methodology. Linkages between strategies and the identified gaps, overlaps and barriers (with each feeding refinement of the other) are paramount.
- *Administrative Simplification*: This analysis focuses on identifying strategies for simplifying administration of the system. The hypothesis is that simplification of the system will (1) reduce inefficiencies and redundancies, and thus contribute to slowing overall cost growth trends and (2) reduce the "hassle factor" for plans and providers, increasing the likelihood that they will continue to "play" in Washington's market. A detailed interview inventory is being used with key informants and will provide the baseline for identifying private-public partnerships to cooperatively reduce the administrative costs of health care.
- *Benefit Distillation*: This research activity is part of simplification but is called out separately. The hypothesis is that there are hundreds of benefit products available across all books of business, that many of these products differ in non-significant ways, and that there may be potential to distill the range of products into a finite set that would maintain consumers' choices while reducing complexity and cost to the system (and increase consumers' ability to comparison shop). A marketplace survey of targeted carriers and third party administrators (with follow-up focus groups and/or interviews for in-depth probing) is being used to gather baseline information to test the theory and to inform design of prototypical sets of products. Depending on findings, industry and community interest in pursuing or pilot testing this voluntary approach to simplification will be assessed via focus groups with a variety of potentially impacted parties (e.g., agents and brokers).
- *Community Initiatives*: This effort focuses on building partnerships with community-based access projects. There are three HRSA Community Access Program (CAP) grantees in Washington State plus numerous other community-based efforts, each focusing on access issues (some looking at systemic change; others focusing on immediate survival). The approach here involves interviews with informed experts; attendance at select community project meetings; and analysis of opportunities for joint pilot testing of ideas (and the concomitant flexibilities and accountabilities needed), for collaborative technical assistance (e.g., data sharing), and for removing barriers to partnership (in either direction).

Findings: There are no findings to report at this time in terms of specific strategies selected or rejected.

Progress:

(1) General: Guiding principles were developed to ensure understanding of the breadth of options and ideas that should be on the table for exploration and discussion. The principles were initially reviewed by the project's oversight panel and have been posted to our Website for input and feedback by interested parties. Progress on specifics is noted below.

(2) Coverage and access: Draft dimensions for analyzing strategies have been developed (e.g., who is affected and how, design or implementation considerations, financing, administration, constraints, and potential impacts--coverage impacts, access impacts, other intended impacts, unintended consequences). An initial literature review has been conducted and a preliminary list of the "universe of options" has been compiled and summarized along the draft dimensions. A session to gather expert opinion was held August 2001 at the annual meeting of the National Association of State Health Policy. Models needed to estimate impacts (e.g., number of people potentially impacted if a strategy were implemented) are in development, as are criteria for discriminating among options (i.e., the filters needed to narrow the field).

(3) Administrative Simplification: See Section 3 on the Health Care Marketplace.

(4) Benefit Distillation: See Section 3 on the Health Care Marketplace.

(5) Community Initiatives: "Informed expert" meetings continue to take place (e.g., Washington Health Foundation, Communities that Won't Wait). A telephone interview protocol was developed. Review of other states' exemplary community initiatives is underway.

Attached in Appendix III are the following: Guiding principles, Administrative simplification interview protocol, Private payer questionnaire, and Community initiatives interview protocol.

With the exception of Questions 4.1 and 4.18, we are not prepared to answer the following questions at this time.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

Predating the grant, the Department of Social and Health Services, Medical Assistance Administration, decided to submit a Medicaid Section 1115 demonstration waiver to allow the state more flexibility to administer its Medicaid program. The waiver is scheduled to be filed on October 31, 2001. We have tried to design pieces of our grant work to support future needs of Medicaid should its waiver be approved (e.g., our work on affordability will be of direct assistance).

4.2 What is the target eligibility group under the expansion?

4.3 How will the program be administered?

4.4 How will outreach and enrollment be conducted?

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)
4.8 How will the program be financed?
4.9 What strategies to contain costs will be used?
4.10 How will services be delivered under the expansion?
4.11 What methods for ensuring quality will be used?
4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?
4.13 How will crowd-out will be avoided and monitored?
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?
4.15 How (and how often) will the program be evaluated?
4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?
4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?
As noted above, we are not yet at this stage of our work. However, given the history of Washington and the current as well as projected state budget deficits, short-term strategies that include any of the following are likely to be considered political non-starters: (1) universal mandates, (2) approaches that increase state expenditures (even with federal match), or (3) approaches that decrease state revenues (e.g., any kind of a B&O tax break to employers who will offer coverage).

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

SECTION 5. CONSENSUS BUILDING STRATEGY

Overview: The consensus building strategy continues to evolve in response to the changing environment. The pieces of our strategy that have remained constant include: (1) use of a state-agency based oversight panel, the parent of which is the Governor's Sub-cabinet on Health, (2) adherence to a guiding principle that speaks to a low key but broadly inclusive process, and (3) recognition that consensus building on strategies viable in Washington will occur over the long run and through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process).

The pieces of our strategy that have evolved include: (1) movement away from a large, multi-constituent advisory committee, (2) use of less formal and less structured avenues for building foundations (e.g., smaller meetings involving top executive-branch officials and industry leaders; informal discussions between the Governor's Health Policy Advisor and Legislative leadership; briefings between project staff and legislative staff), (3) identification of partners working on related issues to create synergies and opportunities for both (e.g., linking-up with Community Access Program grantees, partnering with local foundations like the Washington Health Foundation and HumanLinks), (4) taking advantage of existing meeting opportunities ranging from briefings of small groups to a work session at the state's annual Washington Health Legislative conference[5], (5) creation of a Web-based feedback system accessible by all, and (6) use of ad hoc issue-specific groups rather than standing technical advisory committees.

We anticipate that our process will continue to evolve. The answers below, however, provide a flavor for the process as it now stands.

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

To provide guidance for our work, the grant uses a management oversight panel (MOP), the composition of which is based on the Governor's Sub-cabinet on Health.[6] MOP members were selected because they represent top aides (e.g., deputies, policy and program advisors, executive directors) of Sub-cabinet members and because they are creative thinkers with significant and varied experience and knowledge with respect to health care in general and Washington history in particular. Agencies represented include the Department of Health (public health agency), Department of Social and Health Services – Medical Assistance Administration (Medicaid agency), Health Care Authority (Public Employees and Basic Health agency), Office of Financial Management (Governor's budget office), Governor's Policy Office (Governor's Health Policy Advisor), Office of the Insurance Commissioner (regulatory agency), and the State Board of Health (public health advisory board).

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Various methods are being used to solicit input and feedback. These include: (1) focus groups and ad hoc issue groups built into the substantive work of the project, (2) collaborations on surveys with various partners (e.g., a community-based effort that is pilot testing a public dialogue approach (with a survey as one component) to understand citizen values around health care issues; a web-based survey of registrants for a highly popular annual health policy-legislative conference), (3) a special work session at the annual health policy-legislative conference, (4) a series of regional meetings to be held around the state and in partnership with others (e.g., State Board of Health; Washington Health Foundation) incorporating the work products of the grant, and (5) informal briefings wherever two or more people gather who will listen to us! Some of these activities are currently occurring, others are in development.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

Four primary efforts occurred early in the project: (1) Pre-dating but in anticipation of receipt of the grant, Governor Gary Locke held a summit of health care leaders to discuss a variety of health care concerns, including issues related to the uninsured; (2) A brochure describing the goals and process of the grant was developed, used at various meetings, and posted to our website; (3) A letter was sent from the Governor's Health Policy Advisor to over 100 constituent groups/individuals and to Legislative health care leadership to alert them to the work of the grant and invite their involvement; and (4) A grant-specific website was developed.

The website was initially designed to provide easy access by potential bidders to our Request For Proposals for consultant assistance, rather than as a site to educate, build awareness, and provide input and feedback into our work. The site was recently redesigned with these latter purposes in mind. We launched our first "E-mail Alert" to an interested-party list of over 300 people, notifying them of new items posted to the website and our interest in their feedback. We will be using the website as a primary tool for broad and inclusive access to our work

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

Please see the Executive Summary for this response.

Attached in Appendix III are the following: Guiding principles, Website home page, and Overview of strategy for seeking input and feedback.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

With the exception of Question 6.8, we are not yet ready to answer the following questions.

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

Although it is premature to identify key lessons and recommendations to states, the following are some initial thoughts:

a. **One year is not enough**, especially if there is a high need or desire to inform discussions and build consensus based on state-specific information. Although it is too early to know for certain, there is a growing likelihood that some of the work we want to do and feel is critical to success will have to occur beyond the initial grant year.

b. **Timing is critical**, especially in terms of the need to coordinate with "defining" events. Even though this project and improving access are not solely about state programs and government response, those are critical. For example, in Washington we are trying to be mindful of our Legislative session and the biennial budget building cycle. In Spring 2002, executive branch agencies begin their budget building process during which priorities and resources are aligned for the 03-05 biennium. Work during the following Legislative session, beginning January 2003, determines the final biennial budget (and thus the priorities for state dollars).

c. **Partner with others** who are working on similar and related issues. Synergies, economies of scale regarding effort, understanding differences in foci and desired outcomes, creating an early basis for future consensus building, and cross-pollination of ideas are among some of the advantages.
d. **Be disciplined and flexible**. Be disciplined and focused in conducting the substance the work (e.g., data collection and analysis) but let the process of engaging others be flexible and evolve as information and environment change.
e. **Develop guiding principles** as a means to communicate and educate, set expectations, and jump start discussions on the focus of the work. Different sets of principles, specific to various components of the project, may be helpful. For example, we developed one set of principles for our "approach to the work of the grant" and another set for signaling the breadth of our interest in options for addressing coverage and access.
f. **Build consultants into initial proposals** if their assistance is anticipated. There is precious little time in a one-year project, much of which can be eaten up by a 3-4 month competitive bid process (depending on state rules).

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

As above, recommendations to the federal government are premature given the interim status of this report. However, the following bear mentioning at this point:

1. **Funding for planning, policy development, and pilot testing.** Given growing state budget deficits, states may need to look more than ever to the federal government and/or foundations to support certain activities (at least in the short run of the next 3-5 years). These activities, although often viewed as critical by states, frequently must (and should) take a back seat to meeting the direct and "of-the-moment" needs of populations being served. What is lost, however, is also great – it is the ability to put in motion today what is needed to prevent similar crises tomorrow. The same points can be made, perhaps even more strongly, for community-based programs.
2. **Collaboration among state and community grant efforts.** As future state-planning and community-implementation grants are contemplated, incentives by the grantors to encourage close collaboration may be worth considering.
3. **Flexibility.** As states examine the range of coverage approaches that most efficiently and effectively address their needs, they will be looking to the federal government for streamlined administrative requirements and maximum flexibility (i.e., waivers) to allow development of new options and tools needed to manage their programs.

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

APPENDIX I: BASELINE INFORMATION

Where applicable to our work, the following requested baseline information will be provided in the Final Report.

Population:
Number and percentage of uninsured (current and trend):
Average age of population:
Percent of population living in poverty (<100% FPL):
Primary industries:
Number and percent of employers offering coverage:
Number and percent of self-insured firms:
Payer mix:
Provider competition:
Insurance market reforms:
Eligibility for existing coverage programs (Medicaid/SCHIP/other):
Use of Federal waivers:

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Most of the information regarding our research work will be posted to our website, http://www.ofm.wa.gov/accesshealth/accesshealth.htm, as it becomes available.

APPENDIX III: REFERENCED ATTACHMENTS

1. Bibliography for population and employer-based surveys
2. Overview of population-based surveys
3. Content analysis of population-based surveys
4. Overview of employer-based surveys
5. Content analysis of employer-based surveys
6. Data sources for understanding pathways to coverage and care
   a. Overview of administrative data sources
   b. Overview of safety net data sources
   c. Overview of other data sources
7. Demographics of Washington State's uninsured population
8. Private payer questionnaire (i.e., marketplace survey)
9. Safety net map
10. Administrative simplification interview protocol
11. Community initiatives interview protocol
12. Guiding principles
13. Overview of strategy for seeking input and feedback
14. State Planning Grant website (http://www.ofm.wa.gov/accesshealth/accesshealth.htm)

[1] The winds of change began to significantly appear during the 2001 Legislative session. For example, budget pressures resulted in reducing the funded spaces for Basic Health (BH) (the state-only subsidized program for the working poor) from 133,000 to 125,000. There is now a waiting list of approximately 5,000 individuals. (There is also an initiative on Washington's November ballot to increase the tax on cigarettes and tobacco products in order to [among other things] fund additional spaces in BH.)

[2] To assist in completing grant activities, a consortium of consultants was awarded a contract in June 2001. Members of the consortium are: University of Washington, Health Policy Analysis Program; University of Washington, Department of Family Medicine; Rutgers University, Center for State Health Policy; The RAND Corporation; Foundation for Health Care Quality; and William M. Mercer, Inc.

[3] These results differ from those that would be obtained if the analysis focused on the distribution of uninsured. See Appendix III, Demographics of Washington State's Uninsured Population--Race and Ethnicity of Uninsured Adults, for an example of the distinction. That is: Using the uninsured population as the base, only 6.0 percent of uninsured are American Indian/Alaska Native. In contrast, within the American Indian / Alaska Native group the rate of uninsured is 28.7 percent.

[4] Diana Pearce, Ph.D. with Jennifer Brooks, *The Self-Sufficiency Standard for Washington* State, Prepared for the Washington Association of Churches, the Washington Living Wage Movement and the Washington Self-Sufficiency Standard Committee, September 2001.

[5] The theme of the conference is civic engagement and health system change. Our "breakout" session is titled The State Planning Grant on Access: Can We Talk?

[6] The Governor's Sub-cabinet on Health was created by Governor Gary Locke for the following purposes: (1) to develop and coordinate state health care policy and purchasing strategies, (2) as a forum for the exchange of information, and (3) as a forum to coordinate statewide efforts to provide appropriate, available, cost effective, quality health care and public health services to the citizens of Washington.

APPENDIX III: TABLE OF CONTENTS

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The Effect of Health Insurance Coverage on Doctor and Hospital Visits: 1990 - 1992 (P70-44)

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Who Loses Coverage & for How Long? (P70-54)

Americans with Disabilities: 1994-95 (P70-61)

Who Loses Coverage, and For How Long? (P70-64)

Americans With Disabilities: 1997 (P70-73)

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Working Paper 209: Continuing Research on Use of Administrative Data in SIPP Longitudinal Estimation

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Working Paper 212: The SIPP Cognitive Research Evaluation Experiment - Basic Results and Documentation

Working Paper 216: Compensating for Missing Wave Data in the SIPP

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Working Paper 226: Comparing Certain Effects of Redesign on Data from the SIPP

Working Paper 228: Developing Extended Measures of Well Being - Minimum Income and Subjective Income Assessments

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Washington State Planning Grant on Access to Health Insurance
OVERVIEW OF POPULATION-BASED SURVEYS – Work in Progress

Table 1. Summary

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Periodicity	Over-Sampled Populations	Public Use Data
Behavioral Risk Factor Surveillance System (**BRFSS**)	1994-present	CDC	• State-based • Telephone interviews • Number of states stratified samples to allow regional estimates • Monthly sample size for all states 12,306 (mean for states 236.7) • Allows examination of monthly trends • Yields a representative sample of households with telephones	Yes Permits analysis at the level of 33 local health jurisdictions in Washington	Monthly		Yes
Current Population Survey – March Supplement (**CPS**)	1980-on	Bureau of Labor Statistics and U.S. Census Bureau	• Computer assisted personal interviewing (CAPI) and Computer assisted telephone interviewing (CATI) • 50,000 households • Collects data on all persons in household 15 and older • Survey has been conducted for more than 50 years	Yes	Annual, each March		Yes
Community Tracking Survey (**CTS**)	Household Surveys: 1996; 1998; 2000-1 data collection currently underway Followback survey : 1997-98, 1999-2000	Center for Studying Health Systems Change RWJF	• Household survey administered primarily by telephone, some in-person interviews were included to represent families without working telephones • 60 communities –MSA and non-metropolitan sites • 12 randomly selected to serve as case study sites (larger sample size to report community-specific estimates) • national representation • The total sample will consist of about 60,000 individuals in 33,000 families. Families are defined as insurance	Seattle, WA is one of 12 case study areas; however state-wide estimates are not possible	Two year intervals	"High need" individuals identified in the first round interview may be over-sampled in longitudinal sample	Yes ---------- Possible to request access to restricted data files

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Periodicity	Over-Sampled Populations	Public Use Data
			Families are defined as insurance units, or all individuals in a family that can be covered by a typical private health insurance policy (usually spouses and other dependents less than age 18). Questions were asked about all adults in the family as well as one randomly sampled child.				
Family Health Insurance Survey (**FHIS**)	1993, 1997	RWJF and RAND	In 1993: • Telephone survey (in person interviews those without a phone) • Ten state samples with a total of 27,000 families In 1997: • Telephone survey (in person interviews those without a phone) • Conducted in WA State only • 5,322 families completed shorter version of interview, with data on health insurance coverage, employment and income • 2,537 completed full interview.	Yes	Twice, but the 1997 survey instrument was slightly different	1993 over-sampled uninsured and Medicaid recipients; 1997 over-sampled uninsured, and Medicaid and BHP enrollees	1993 is public; 1997 data is not. WA State has the 1997 data
Medical Expenditure Panel Survey-Household Component (**MEPS-HC**)	1996,1997, 1998	AHRQ and NCHS/ USDHSS	• In person interviews • Nationally representative • The 1996 MEPS-HC sample is a nationally representative subsample of the prior year's National Health Interview Survey (NHIS) • Links its components to the National Health Interview Survey, which enhances the analytic capabilities of both surveys • 10,500 families and 24,000 individuals	No	Annual	Policy relevant population subgroups, such as functionally impaired adults, children with activity limitations, expected high-cost individuals, expected low-	Yes

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Periodicity	Over-Sampled Populations	Public Use Data
			across the U.S. • Six rounds of interviews over 2 years			income families, Hispanics and Blacks	
National Health Interview Survey (**NHIS**)	1957-on; redesigned in 1995	NCHS/ USDHSS	• Continuing national survey utilizing a stratified multi-stage sample design • 36,000 to 47,000 households per year, including approximately 106,000 individuals • Sample size is too small to support state estimates	No	Yearly	African Americans and Latinos	Yes
National Survey of American Families (**NSAF**)	1997, 1999	Urban Institute (Assessing the New Federalism) *Consortium of private funders	• Household telephone surveys • Non-telephone households included • 13 states and national samples • over 44,000 households yielding information on over 100,000 people	Yes, Sampled 5,757 adults in WA; additional sample of most knowledgeable adult interviewed for children	Two year intervals	Below 200% poverty line (18,000 households – 52% of target sample)	Yes
SIPP	1984-on; redesigned in 1996	U.S. Census Bureau	• Continuous series of national panels • 14,000 to 36,700 interviewed households • Nationally representative sample • Each respondent is interviewed once every four months for 2.5 years, which provides longitudinal data • Interviews conducted in person and by telephone • All household members 15 and over are interviewed by self-response; proxies are used as needed	No	Yearly		Yes
Washington	1998, 2000	WA State	• Telephone surveys of 7,279	Yes	2 year	Racial minority	Yes

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Periodicity	Over-Sampled Populations	Public Use Data
State Population Survey (WSPS)		Office of Financial Management	households in spring of 1998 • Eight geographical areas were established as primary sampling units for which results could be tabulated from the basic data collection		intervals	groups	
Washington WorkFirst Study (WWFS)	1999-present	Social and Economic Science Research Center, at Washington State University	• Sample of 3000 current and former WorkFirst clients (Workfirst is Washington's welfare reform program) • Respondents are reinterviewed annually • Survey data is linked to administrative data • Focus is not on healthcare, although measures of health and insurance are included	Yes	Annual		Yes

Table 2. Units of Analysis

	Units of Analysis			
Survey (see key)	Address	Household	Family	Individual
BRFSS				X
CPS		X		X
CTS			X	X
FHIS		X (for part 1 only)	X	X
MEPS-HC		X		
NHIS		X	X	X
NSAF			X	X
SIPP	X		X	X
WSPS		X	X	X
WWFS		X	X	X

Table 3. Support of Local Area Estimates

	Geographic Areas						
Survey (see key)	National	Groups of States	Washington State	MSAs	Counties	Cities	Other
BRFSS	X	X	X				
CPS	X	Census Divisions	X[1]	Large MSAs[2]	Large Countie[2]	Large Cities[2]	
CTS	X		Seattle only				60 CTS Sites
FHIS			X	X	X	X	Zip code
MEPS-HC	X	Census Regions		Special Arrangement	Special Arrangement	Special Arrangement	
NHIS	X	Census Regions	Special Arrangement	Special Arrangement	Special Arrangement	Special Arrangement	
NSAF	X	X	X	X	X	X	Zip code
SIPP	X	X					
WSPS			X		King, Clark, and Spokane counties individually, otherwise regionally organized groupings of smaller counties		
WWFS			X				

[1] State estimates should be used with caution, particularly for small states, as standard errors may be large. The Census Bureau published state estimates on a 3-year average from the March CPS to create more stable estimates for making state-to-state comparisons.
[2] Estimates for these areas are possible, but may be unreliable due to large standard errors.

Table 4: Support of Geographic Linkage of Contextual Information

	Geographic Areas					
Survey (see key)	Groups of States	Individual States	MSAs	Counties	Cities	Other
BRFSS	X	X				
CPS		X	X	With pop. Over 100,000	With pop. Over 100,000	
CTS		Special Arrangement[1]		Special Arrangement[1]		CTS Site by Special Arrangement[a]
FHIS		X	X	X	X	Zip code
MEPS-HC	Special Arrangement[1]	Special Arrangement[1]	Special Arrangement[1]	Special Arrangement[1]	Special Arrangement[1]	
NHIS	X	Special Arrangement[1]	Special Arrangement[1]	Special Arrangement[1]	Special Arrangement[1]	
NSAF	X	X	X	X	X	X
SIPP	X					
WSPS		X		King, Clark, and Spokane counties individually, otherwise regionally organized groupings of smaller counties		
WWFS		X				

[1] Limited area estimates are available by special request through a data center.

Table 5: Precision of Estimates

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
BRFSS	• More than 118,348 interviews nationally in 1998 • In 2000, 3,584 interviews were conducted for WA	• Households selected through random sampling of phone numbers. • Sampling strategy may vary slightly from state to state, but all are comparable because they yield a representative sample	One adult (18+) is randomly selected from each household.	Yes
CPS	64,990 nationally	• Panel design in which household is interviewed for 4 consecutive months, then have an 8-month rest period, then interviewed for the another four months. • Replenish sample each month	• Individual adult responds for all household residents. • If individual moves from household, they are dropped from sample.	Yes
CTS	Nearly 33,000 families and over 60,000	• Nationally representative cross-sectional survey • Data are collected in 60 randomly	• Individual adult responds for all household adult	No

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
	individuals	selected communities nationwide • Twelve communities are selected to be case-study areas, including Seattle, WA.	residents. • In addition, respondent supplies information on one randomly selected child in household	
FHIS	Part 1: 5,322 families and 11,475 persons Part 2: 2537 families and 5871 persons	• Random digit dialing was used for general population frame • For Medicaid and BHP samples lists of enrollees were used • RDD sample was stratified based on geography and health insurance types • Respondents were screened using Part 1 of the survey; only a subsample was asked to complete entire survey; this was designed to meet stratification goals	Interviewee responds for self and all other members of household.	Yes

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
MEPS-HC	• Between 8,000 and 10,000 households per panel • Every 5 years the sample size is increased	• Rotating panel design; preliminary contact followed by six rounds of interviews over a 2 1/2 year period. • New series launched each year to provide overlapping panels.	One family respondent reports for himself or herself and other family members.	No, and it is not possible to obtain state-level estimates.

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
NHIS	Approximately 43,000 households and 106,000 individuals	• Stratified multi-stage sample design • NHIS uses stratification, clustering and differential sampling rates • Cross-sectional	• For family core: All family members are invited to respond for themselves. For children and adults who are not at home, a responsible adult family member may respond. • For adult core: One randomly selected adult responds for herself (no proxies permitted). • For child core: Most knowledgeable adult responds.	No

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
NSAF	In 1999, 42,000 households and more than 109,000 non-elderly	• Main sample consisted of a random-digit dial survey of households with telephones • Also included area probability sample of households without telephones	Most knowledgeable adult responded for herself, spouse/partner, and family.	
SIPP	14,000 to 36,700 interviewed households	• The survey design is a continuous series of national panels. • The duration of each panel ranges from 2 1/2 years to 4 years. • The SIPP sample is a multistage-stratified sample of the U.S. civilian noninstitutionalized population.	• Interviews are conducted with all individuals aged 15 and older. Proxies are permitted when necessary. • If individual moves from household, they are followed to new household, and new housemates are included in sample.	No
WSPS	7,279 in 1998	• General population sample was drawn from a random sample of all WA households • General population sample is stratified into eight geographic regions (target for each region was	Interviewee responds for self and all other members of household.	Yes

Survey (see key)	Sample size	Survey design	Interviewee	Designed for state-level estimates
		750 respondents). • Supplemental statewide samples of African Americans, Asians, Hispanics, and Native Americans were drawn from Census tracts containing the highest number of the ethnic minority group. Target for each group was 400 respondents.		
WWFS	3,037 respondents as of 5/01	• Sample restricted to current and former WorkFirst clients, who are reinterviewed annually.	Interviewee responds for self and all other members of household.	Yes

Table 6: Bias of estimates

Survey (see key)	Interview mode	Response rate	Potential sources of non-response bias
BRFSS	Telephone	76.5% nationally	• Only households with telephones are included • Only one person per household is interviewed, may not be representative
CTS	Primarily telephone interviews; additional in person interviews for sample of households without telephone.	65% between 1996-1997 (Lewis et al., 1998)	To reduce non-response bias, included a field sample of households without telephones
CPS	In person and by telephone, varies over the course of interviews	• 93% overall (Fronstein, SHADAC) 80-82% completed the March supplement • 43.2% in 1998 (Atrostic et al. 1999	
FHIS	Primarily telephone interviews; additional in person interviews for sample of households without telephone.	• 69.2% for RDD sample • 42.9% for Medicaid sample • 73.4% for BHP list sample • 51.5% for field sample	To reduce non-response bias, included a field sample of households without telephones
MEPS-HC	In person; except that initial contact is by mail and telephone and final interview is by telephone	65.2% for Panel 4 in early 2000	• Reduces bias through mail follow-up for households without phones.

Survey (see key)	Interview mode	Response rate	Potential sources of non-response bias
NHIS	Face-to-face interviews	• 67.5% in 1998 (Atrostic et al. 1999) • reported as greater than 90% on NCHS webpage	
NSAF	• Telephone • For those interviewees without telephones, in person interviewers provided respondents with cellular phones, and interviews were conducted via cell phones	Approximately 64% in 1999	To reduce non-response bias, included a field sample of households without telephones
SIPP	Face-to-face interviews, with follow-ups conducted over telephone	79.1% in 1998 (Atrostic et al. 1999)	
WSPS	Telephone	• 59% for general population • 43% for expanded smple	Only households with telephones were included
WWFS		*Waiting for data*	

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CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
HEALTH INSURANCE COVERAGE										
Any health insurance coverage										X(298)
Primary type of health care coverage									X(63)	
Number of health insurance plans currently enrolled in			X(20)	X(17)			X (E-1)			
Source of Coverage										
Covered by Employer or Union	X(5)	X	X(11)	X(18)		X(30/	X(E-1)	X(J6)	X(62)	X(299)
Name of Employer or Union		X	X(22)		X(28-4/46)					
Policy Holder		X	X(20)	X(17)	X(28-16	X(33)	X(E-1)			
Health insurance in respondents name?		X						X(J5)		
Health ins. In respondent's name or as family member of someone else?		X						X(J5)		
Name of Health Plan			X(20)	X(18)		X(31/2)				
Plan / group #			X(23)							
Extended through COBRA					*X(28-192)					
Covered as a temporary worker		X							X(21)	
Covered by former employer		X						X(J6)		
Covered by spouse's employer or union		X								X(299)
Covered by someone not living in household	X(5)	X	X(13)					X(J7)	X(63)	
Purchased Health Plan	X(5)	X	X(12)	X(18)		X(30)	X(E-2)	X(J6)	X(62)	X(299)
Medicare	X(5)	X	X(13)	X(13)		X(30)	X(E-3)	X(J1)	X(62)	X(299)
Medicare supplemental policies or Medigap		X	X(33)			X(30)				
Medicare Card Number					X(28-50)	X(30)				
Has Medicare for disability or condition		X			X(28-20)					
Type of Medicare coverage		X			*X(28-52	X(30)				
When did Medicare coverage start (dates of coverage)					*X(28-54)					
In Medicare HMO		X			X(28-56)	X(31)				
Features of Medicare HMO					*X(28-58)					
Plan letter for Medicare Managed Care					X(28-105)					
CHAMPUS	X(5)	X	X(15)	X(16)		X(30)	X(E-4)	X(J6)	X(62)	
TRICARE	X(5)	X	X(15)			X(30)	X(E-4)	X(J6)	X(62)	

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CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
CHAMP-VA	X(5)	X	X(15)	X(16)		X(30)	X(E-4)	X(J6)	X(62)	
VA/ Other Military Health Insurance	X(5)	X	X(15)	X(16)		X(30)	X(E-4)	X(J6)	X(62)	X(300)
Indian Health Service	X(5)	X	X(16)			X(30)	X(E-4)		X(64)	X(300)
Medicaid	X(5)	X	X(14)	X(14)		X(30)	X(E-5)	X(J10	X(62)	X(298)
Medicaid card questions					*X(28-71)					
Medicaid HMO questions					*X(28-73)					
Medicaid and Medicare				X(3)						
State Specific Program		X	X(17)	X(15)		X(30)	X(E-5)	X(J10	X(63)	X(298)
Washington Basic Health Plan		X							*X(63)*	X(298)
Type of health coverage prior to WA BHP									X(63)	
Healthy Options		X							*X(63)*	X(298)
DSHS Medical Assistance Programs		X							X(62)	X(298)
Covered by another source of insurance		X		X(22)			X(E-13)			X(298)
Additional State Programs										
AFDC					X(28-39)					
SSI					X(28-39)					
WIC					X(28-39)					
Public Health Clinic					X(28-39)					
Type of Insurance for Self-employed										
From professional org.					X(28-8)					
From small business group					X(28-8)					
From a union					X(28-8)					
From health insurance purchasing alliance					X(28-8)					
From insurance agent					X(28-8)					
From HMO					X(28-8)					
Through a School					X(28-46)					
From previous employer					X(28-8)					
From previous employer (COBRA)					X(28-8)					
Family members' coverage										
Family members covered by plan		X	X(21)	X(97)		X(32)	X(E-1)	X(J6)	X(64)	
Plan covers someone not living in household?		X						X(J6)		
Coverage for dependant persons not living in home		X			X(28-180)					
Which of past 4 months were your children covered by Medicaid / public assistance?								X(J3)		
Premiums and out-of-pocket expenses										

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
Insurance Premium			X(24)	X(18)	*X(28-10	X(24)				
Does employer pay all, part, or none of premium?		X						X(J6)		
Self-purchased plan insurance premium										X(300)
Frequency of payment for self-purchased plans										X(300)
Who pays for health plan						X(33)				
In past 12 months how much spent on medical/dental care						X(35)				
Insurance History/Period of Coverage										
Insurance card info (incl.effective date).					X(28-101)					
Previous Health Plan			X(44)		*X(28-114)					
Years enrolled in HMO plans			X(48)							
Enrolled in past 12 months			X(23)							
Who was covered in past 12 months				X(22)	X(28-177)		X(E-11)?			
Continuous coverage in past 12 months				X(24)		X(35)	X(E-12)			
Coverage for how many of the past 12 months			X(43)	X(22)	X(28-120)		X(E-12)			
Covered part of or whole month					X(28-179)					
How long since last without coverage								X(J8)		
Did health insurance continue after stopped working					X(28-191)					
Low option or high option					*X(28-88)					
Employment info										
Health Insurance available through employer		X							X(64)	
Employer offers more than one plan			X(26)							
Type of business									X(17)	
For those without coverage										
No coverage				X(21)	X(28-113)?		X(E-6)			
No insurance coverage in past 12 months	X(7)			X(24)			X (E-11)			
How long since coverage	X (7)				X(28-11	X(35)		X(J8)		
Who was not covered in past 12 months				X(24)			X (E-14)			
How many of the past 12 months with no health insurance				X(24)		X(35)	X(E-14)			
Reason health insurance ended			X(43)	X		*X(35	X			

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
What date did health insurance end					X(28-168)					
Covered whole or part of month					X(28-168)					
Who is no longer covered					X(28-172)					
Denied from or limited in insurance coverage due to poor health			X(50)		X(28-115)					
Condition causing denial for health ins.					X(28-116)					
Condition causing limited health ins.					*X(28-121)					
Ever tried to purchase health insurance					X(28-117)					
Reason for no coverage	X(52)		X(43)	X				X(J8)	X(64)	X(301)
Attitudes about coverage										
Opinion of Health Insurance Coverage			X(668	X(25)						
Plan characteristics										
Type of plan			*X	X(22)			X(E-12)			
HMO, IPS or PPO						X(34)				
HMO			X(25)	X(18)	X(28-183	X(31/	X (E-8)			
List of providers			X(25)			X(31/	X(E-8)			
Primary Care Physician for Routine Care			X(24)			X(31/	X(E-8)			
Referrals			X(25)			X(31)	X(E-9)			
Cost without referral or out of plan			X(26)			X(34)				
Services Covered										
Prescription drugs covered				X(20)	X(28-183)					
Physician Visits Covered				X(19)	X(28-183)					
Any part of nursing home					X(28-183)					
Dental	X(61)									
Eye Care					X(28-183)					
Other Coverage										
Extra cash for hospital stays					X(28-183)					
Serious disease or dread disease					X(28-183)					
disability					X(28-183)					
Workers comp.					X(28-183)					
accident					X(28-183)					

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
UTILIZATION										
Utilization within past year										
Overnight Hospital Care			X(51)	X(35)		X(AC	X (F-2)			X(307)
Admitted through ER			X(53)							
Number of times in hospital overnight			X(52)	X(35)		X(AC-24)				X(307)
Nights in hospital			X(53)	X(35)		X(AC-24)				
City or Town of Hospital				X(35)						
Delivered Baby			X(52)				X(F-2)			
Dentist Visits	X(59)					X(AC	X(F-2)			
ER visits	X (56)		X(53)	X(36a)		**X(A	X (F-3)			X(307)
visit doctor/outpatient clinc										X(306)
Visits to hospital outpatient clinic				X(36a)						
Mental health services			X(57)			X(AC	X(F-3)			X(307)
Home health care			X(58)			X(AC-24)				
Medical personnel other than doctors			X(55)	*X(35)		*X(AC	X(F-3)			
Doctor visits	X(56)		X(55)	X(36)		**X(A	X(F-3)			
Place of doctors visits				X(36)						
Number of doctor visits						**X(AC-24)				
Received care from doctor more than 10 times						X(28)				
How long since last saw or talked to doctor						**X(AC-25)				
Surgical procedures			X(56)			X(AC-24)				
Number of different times had surgery						X(AC-24)				
Doctor specializing in women's health						X(AC-23)				
Specialist						X(AC-23)				
Does Doctor treat children and adults						X(AC-23)				
Received medical care in home?										X(307)
During how many of past 12 months received care at home						X(AC-24)				
Total number of home visits						**X(AC-24)				
Preventive Care Utilization										
Breast Physical Exam							X(F-4)			
Pap Smear							X(F-4)			
Flu shot	X(66)		X(58)							
Immunization questions				X(37)	*X(5-46)					
Child check-ups	X									X(310)
Time since last check-up	X(8)		X(72)							

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
Mammogram	X(28)		X(58)	X(39)						
Time of last Mammogram	X(28)		X(59)	X(39)						
Reason for Mammogram	X(29)									
Breast physical exam	X(29)			X(40)						
Time of last Breast Exam	X(29)			X(40)						
Reason for breast exam	X(30)									
Pap Smear	X(30)			X(41)						
Time of last pap smear	X(30)			X(41)						
Reason for pap smear	X(31)									
Pneumonia Vaccination	X(66)									

**NHIS also asks utilization questions about the past two weeks (Adult Core has utilization within the past year, Family Core within the past two weeks)

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
USUAL SOURCE OF CARE										
Has a usual place of care	X (54)		X(63)	X(26)	X(26-1)	X(AC	X (F-5)			
Reason for no usual source of care			X(65)	X(28)	X(26-2)					
Location										
Name of place of usual source						X(AC-20)				
Doctor's Office	X(54)		X(63)	X(26)	X(26-1)	X(AC	X (F-5)			
Hospital ER	X(54)		X(63)	X(26)	X(26-6)	X(AC	X(F-5)			
Hospital Outpatient dept.	X(54)		X(63)	X(26)	X(26-6)	X(AC	X(F-5)			
Clinic	X(54)			X(26)	X(26-1/6	X(AC	X(F-5)			
Is clinic or outpatient dept. operated by the hospital (or is private dr's office located at hospital)					X(26-7)					
Urgent Care	X(54)									
HMO	X(54)		X(63)	X(26)		X(AC	X(F-5)			
Community or Migrant Health Center				X(26)						
Indian Health Service				X(26)						
Public Health Dept.				X(26)						
Other Clinic or Health Center			X(63)		X(26-1/					
VA Facility										
Company Industrial Clinic				X(26)						
Mental Health Clinic							X(F-5)			
School clinic				X(26)						
Walk in Center				X(26)						
Other	X(54)		X(63)	X(26)	X(26-6)	X(AC	X(F-5)			
Reason for place of usual source of care					X(26-8)					
Provider Type										
Uses a specific physician or provider	X (55)		X(64)		X(26-4)					
TYPE OF PHYSICIAN OR PROVIDER:										
Doctor			X(64)		X(26-10)					
Nurse			X(64)		X(26-11)					
Other			X(64)		X(26-11)					
Reason for selecting health care provider				X(27)	X(26-9)					
Doctor's specialty					X(26-12)					
How do you usually get to doctor's office					X(26-10)					

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
Does provider have office hours on nights and weekends					X(26-15)					
Would you go to provider for:										
New health problems					X(26-15)					
Preventive care					X(26-15)	X(AC-20)				
Referrals to other health professionals					X(26-15)					
Experiences making appointments					*X(26-16/17)					
In past year changed usual source of care			X(64)		X(26-20)	X(AC-20)				
Reason for change in usual source of care			X(65)		X(26-21)	X(AC-20)				

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
BARRIERS TO CARE AND UNMET NEEDS										
Barriers										
Financial	X(7)		X(60)	X(29)	X(26-22/	X(25)				
Insurance			X(60)	X(29)	X(26-24)					
Geographic			X(60)	X(29)	X(26-24)					
Transportation				X(29)	X(26-24)	X(AC-21)				
Doctor's office hours			X(60)			X(AC-21)				
Problems making appointments			X(61)			X(AC-21)				
Don't know how to make appointment				X(29)						
Beliefs				X(29)						
Self-assessment				X(29)						
Additional barriers to care										
Wait in physician's office						X(AC-21)				
Pre-existing condition					X(26-24)					
Hearing impairment or loss					X(26-24)					
Different language					X(26-24)					
Hard to get into building					X(26-24)					
Hard to get around inside building					X(26-24)					
No appropriate equipment in building					X(26-24)					
Couldn't get time off work					X(26-24)					
Didn't know where to get care					X(26-24)					
Was refused services					X(26-24)					
Couldn't get child care					X(26-24)					
Didn't have the time					X(26-24)					
Unmet or delayed needs										
Medical	X(7)		X(60)	X(30)	X(26-22)	X(25)	X (F-6)			
Emergency				X(29)						
Surgical							X (F-5)			
Dental				X(33)		X(AC	X (F-7)			
Mental Health						X(AC	X (F-8)			
Prescription Drugs				X(31)	X(26-22)	X(AC	X(F-9)			
Reason for unmet / delayed need			X(60)	X(29)			X (F-6-9)			

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
SATISFACTION										
Satisfaction with:										
Medical Care				X(44)			X(B-1)			
Health Plan				X(45)						
Health Care Services	X(58)		X(69)	X(44)						
Doctor's explanations / listening / respect	X(57)		X(77)	X(44)	*X(26-18)					
Time waiting for appointment				X(45)						
Time waiting in office				X(45)						
Health Care System				X(46)						
Doctors spent enough time with you	X(58)									
Choice of primary care doctors			X(70)							
Choice / availability of specialists			X(71)							
Ease of obtaining answers over the phone										
Professional staff at provider's office					X(26-19)					
Quality of care from provider					X(26-19)					

Washington State Planning Grant on Access to Health Insurance

CONTENT ANALYSIS OF POPULATION-BASED SURVEYS - Work in Progress

Content Analysis Domains	BRFSS	CPS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP	WSPS	WWFS
HEALTH STATUS										
Self-assessed health status	X(2)	X	X(78)	X(42)		X(17)	X(F-1)			X(306)
Number of days in the last 30 that physical health was not good	X(2)									
Child's health Status					*X(5-41-	*X(14	X (B-1)			
Health compared to 12 months ago							X(F-1)			
Limitations on activities	X(3)		X(78)		*X(5-14-24)		X(F-1)			
Unable to do certain kinds or amounts of work			X(80)	X(42)	*X	X(14)				X(308)
Unable to work			X(80)	X(42)	X(5-23)	X(15)				X(308)
Limit kinds or amounts of vigorous activities				X(43)	*X					
Limit kinds or amounts of moderate activities			X(68)	X(43)	*X					
Mental Health	X(3)		X(80)		*X(15)					
Require help or supervision with everyday activities					X*(5-2-8)					
Require help with personal care needs						*X(14)				
Reason for requiring supervision					X*(5-2-8)					
Use aids or special equipment					X(5-9)	X(15)				
Eyeglasses or contacts					X(5-31)					
Difficulty seeing with eyeglasses or contacts					*X(5-31)					
Blind					X(5-34)					
Hearing aid					X(5-36)					
Difficulty hearing with hearing aid					*X(5-37)					
Deaf					X(5-39)					
Medical conditions						*X(16)				

Washington State Planning Grant on Access to Health Insurance
OVERVIEW OF EMPLOYER-BASED SURVEYS – Work in Progress

Table 1. Summary

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Likelihood of study continuing	Periodicity	Data Availability
Employer Health Insurance Survey (E**HIS**)	1993, 1997	RWJF and RAND	• Computer-assisted telephone interviews, self-administered questionnaires, and administrative records data • National probability sample of private and public employers • Samples of private employers selected from Dun's Market Identifiers • Excludes self-employed persons with no employees • Data regarding state employees were obtained from each state government • Data regarding federal employees taken from US Bureau of Labor Statistics and Office of Personnel Management	Yes	Very unlikely, unless it receives alternative funding.	Twice	Data are available on a public access file
Medical Expenditure Panel Survey-Insurance Component (**MEPS-IC**)	1996 through present	AHRQ	• An annual panel survey • Data collected through a prescreening telephone interview, a mailed questionnaire, and a telephone follow-up for non-respondents • Sample of business establishments and governments throughout the United States, chosen from a number of sources: 1) a list of employers or other insurance providers identified by MEPS Household Component respondents who report having private health insurance at the Round 1 interview, 2) a Bureau of the Census list frame of private-sector business establishments, 3) the Census of Governments from the Bureau of the Census, and 4) an Internal Revenue	Yes	Very high likelihood of study continuing into future	Annual	Data are currently available for 1996-1998 studies Raw data are not available but it is possible to request specific data from AHRQ

Survey Name (Code)	Years Conducted Since 1990	Sponsorship	Survey Design	WA-specific data?	Likelihood of study continuing	Periodicity	Data Availability
			Service list of the self-employed. • Data collected from the first sampling frame (employers and other insurance providers) are linked back to data provided by the MEPS-HC respondents				

Table 2. Units of Analysis

Survey (see key)	**Units of Analysis**			
	State	Business Size	Industry	Worker Type (# hours worked)
EHIS	X	X	Available, although estimates may not be reliable	X
MEPS-IC	X	X	Available through special arrangement; although the estimates may not be reliable	X

Table 3. Support of Local Area Estimates

	Geographic Areas						
Survey (see key)	National	Groups of States	Washington State	MSAs	Counties	Cities	Other
EHIS			X		X (by special arrangement)		
MEPS-IC	X	X	X				

Table 4: Support of Geographic Linkage of Contextual Information

	Geographic Areas					
Survey (see key)	Groups of States	Individual States	MSAs	Counties	Cities	Other
EHIS		X		X (By special arrangement)		
MEPS-IC	X	X				

Washington State Planning Grant on Access to Health Insurance
CONTENT ANALYSIS OF EMPLOYER-BASED SURVEYS - Work in Progress

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
COMPANY SIZE/# EMPLOYEES			
Company overall/Firm			
# of locations		A	2
# of employees nationwide	5	A	2-3
# of employees in state		A	3
Company at this location/Establishment			
# active employees		A	4
# permanent/temporary employees		A	6-7
# union members	5, not sure if this is location only or all?	A	8
# company retirees 65 or over	5, not sure if this is location only or all?	A	9
INSURANCE COVERAGE			
Does employer provide insurance?	1		A12-A14
Does company make available or contribute to the cost of any health insurance plans for employees or retirees?	1	A	I-40
Years company provided/contributed to health insurance		A	10
Company ever denied coverage?		A	10
Employee Eligibility:			
Waiting period for new employees (length of period)	4	A	10-11
Hours for insurance eligibility?		A	11
Number employees eligible for insurance	5	A	12-13
Full Time/Part Time	5		
Temporary or Seasonal Employee eligibility	5	A	12-13
Retiree eligibility (other than through COBRA)		A	12-13
	5	A	13
How Insurance Purchased:			
Is insurance purchased through alliance/associations	2	A	14
Features of cooperative/alliance		A	15
Does company or employees select plans?			
Did company consult agent or broker to evaluate benefits?		A	15
Did broker give information on plans not associated with cooperative/ alliance?		A	15
Premium quotes outside of cooperative/alliance		A	16-17
Plans offered to employees at this location:			
Number of plans offered to employees	Inferred	A	21-23
Plan choice same as last year?		A	24
All plans administered by same company?		A	24
Plan administrator requires only its plans be offered?		A	25
Plan enrollment:			

Washington State Planning Grant on Access to Health Insurance
CONTENT ANALYSIS OF EMPLOYER-BASED SURVEYS - Work in Progress

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
Month plan year begins	2	A	25
Open enrollment period		A	25-26
Enrollments in all plans		A	26-30
Cost:			
Annual cost of coverage for all hospital/physician plans offered *at this location*	4		
Employer contribution policy for health insurance		A	31
Amount company spent for insurance in most recent year		A	32-35
Percent employer contributions to retirees' premiums		A	35
Increase or decrease in cost from last year		A	36
Plan Selection Decisions:			
Who makes decisions		A	36-37
Performance measures		A	37
Evaluation materials to employees		A	38

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
SPECIFIC PLAN INFORMATION; Asked for each plan		C	1-53
Type of plan			
Name of plan	2	C	15-18
Name of insurance carrier	2	C	15-18
Type of insurance plan	2	C	3-7
Self or fully insured	2	C	14-18
If self-insured plan:			
Self-administered or administered by third party?	2		
Stop loss policy?	2	C	19
Type and amount of stop loss		C	19-21
Number of enrollees covered by stop loss		C	21
Enrollees in plan	3	C	8-13
# enrollees excluding dependents	3	X	
# active employees enrolled	3	C	8
# former employees enrolled through COBRA	3	C	9
# retirees enrolled	3	C	10
# enrollees with single coverage	3	X	
Premiums and Employer/Employee Contributions:			
For self-insured plan:			
COBRA premiums: single and family of four	2	C	32-34
During most recent reporting period, actual paid claims, administrative costs, stop loss costs	2	C	35-36
Total number of enrollments		C	36
Premium equivalent calculated?		C	36-37
For fully insured plans and self-insured plans with premium equivalent:			
Premium/premium equivalent for **employee-only** coverage employer contribution;	3	C	38-41
employee contribution for employee only coverage	3		
Premium/premium equivalent for **family** coverage employer contribution	3	C	42-46
employee contribution for family coverage	3		
Is premium/premium equivalent same for retirees 65+	3	C	41
Did premiums differ by:			
age	3	C	40
sex	3	C	40
number of persons (within family coverage)	3	C	42
wage or salary levels	3		
other	3		
Did amount of employee contribution differ by:			
employee categories (e.g., full-time, part-time,retiree)	3		
age		C	40
wage or salary levels		C	40

Washington State Planning Grant on Access to Health Insurance
CONTENT ANALYSIS OF EMPLOYER-BASED SURVEYS - Work in Progress

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
Plan Administrator		C	22
Insurance plan benefits:			
Require primary care physician **referral** to specialist	2	C	6?
Exclusion for **pre-existing conditions**?	4	C	22-23
Did exclusion for pre-existing conditions happen in [year of survey]	4	C	23
Waiting period for pre-existing conditions	4	C	23
Deductibles			
Total individual and family annual deductible	3	C	24-27
Deductible for physican care (answer this and hospital care if not answered total annual deductible)	3	C	24
Deductible for hospital care	3	C	24/27
Family deductible met if a number of individuals met their individual deductibles	3		
Coinsurance/copayments		C	28-31
Enrollee cost for an overnight hospital stay ($ or %)	3	C	30-31
Enrollee cost for an office visit ($ or %)	3	C	28
Annual individual out-of-pocket limit	4	C	31-32
Annual family out-of-pocket limit	4		
Annual maximum plan would pay for individual; lifetime and one year?	3		
Any enrollee receive a direct subsidy or contribution (e.g., from a union or government)?	2		
Premium includes **life insurance**	3		
Premium includes **disability insurance**	3		
Services included in plan:			
100% well-baby care	4		
Adult immunizations	4		
Adult routine physical exams	4		
Alcohol/substance abuse treatment	4		
Child immunizations	4		
Chiropractic care	4		
Home health care	4		
Inpatient hospital stays		C	7
Inpatient mental illness	4		
Nursing home care	4		
Mental health		C	7
Office visits for prenatal care	4		
Orthodontic care	4	C	7
Other non-physician providers	4		
Outpatient mental illness	4		
Outpatient prescriptions	4	C	7
Physician services		C	7
Routine dental care	4	C	7
Routine mammograms	4		

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
Routine pap smears	4		
Vision care		C	7
Well child-care, 1-4 years	4		
Well-baby care, under 1 year	4		
Offer optional coverage at additional premium:	4		
dental	4		
vision	4		
prescription drugs	4		
long-term care	4		
Total amount paid for these services	4		
Contract specifications			
For employers with fewer than 50 employees (in state):			
Guaranteed renewal of contract		C	47
Minimum employer contribution?		C	47
Minimum percent of employees must enroll?		C	47
Employees report prior history		C	48
For self-insured plans:			
Contract directly with physician groups or hospitals		C	48
Carve outs		C	48
How single service and general plans are "packaged":		C	52-53
Plan still offered in subsequent year?	4		
Plan replaced?	4		
If replaced, for replacement plan, what were:	4		
Single enrollment	4		
Family enrollment	4		
Single premium	4		
Family premium	4		
For companies that have pooled purchasing arrangement, is THIS plan:			
Purchased through cooperative/alliance?		C	1
Purchased through a business coalition?		C	1
Purchased through a MEWA or MET?	2	C	2
Sponsored by trade or professional association	asked of all; 2	C	2
name, name of insurance representative, address of trade or professional association	2		
Sponsored by a union?	asked of all; 2	C	2
name, local number, name of insurance representative, address of union	2		

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
ESTABLISHMENT AND EMPLOYEE CHARACTERISTICS			
Length company in business	5	D	1
Industry	5	D	2-6
Ownership type	5		
For profit vs. non-profit	5		
Number of employees on payroll	5	D	7
full-time	5	X	
part-time	5	X	
temporary/seasonal employees	5	X	
Number of full- and part-time employees added to payroll in prior year		D	8
Number of permanent employees removed from payroll in past year		D	8-9
Distribution of hours permanent employees work		D	9
Number of hours/week must work to be full-time	5		
Age distribution for permanent employees		D	10
Number of employees over 50	5		
Percent of permanent female employees	(# of women)	D	11
Number of wage vs salary workers		D	11
Wage distribution for hourly workers	5	D	12
Earnings distribution for salaried workers		D	13-14
Gross amount of payroll		D	15
Number of labor hours included in payroll		D	15
Total sick days during most recent fiscal year		D	16
Fringe benefits offered			
Paid vacation	5		
Paid sick leave	5		
Life insurance	5		
Disability insurance	5		
Retirement/pension plans	5		
MSAs	5		
Flexible spending accounts	5		
Cafeteria plan	5		
Eligible/Enrolled by Plan			
Total number of employees eligible	5	C	8
full-time	5		
part-time	5		
temporary/seasonal employees	5		
Total number of employees enrolled	5	C	8
full-time	5		
part-time	5		
temporary/seasonal employees	5		

Washington State Planning Grant on Access to Health Insurance
CONTENT ANALYSIS OF EMPLOYER-BASED SURVEYS - Work in Progress

Content Analysis Domains	MEPS-IC	EHIS	
	Page	Section	Page
FIRMS THAT DO NOT OFFER HEALTH INSURANCE			
Alternative company health care expense assistance:			
Payment for insurance under spouse's plan		B	1
Voucher or money to purchase health insurance	6	B	1
used for health insurance/health care only	6		
average per employee value of voucher	6		
Direct payment of medical bills	6	B	1
Prior insurance purchase:			
Ever denied health insurance?		B	2
Health insurance offered within past two years?		B	2
Health insurance offered since 1991	6		
Year last offered insurance	6		
If no: Company looked into purchasing insurance?		B	2
Premium quote within past two years?		B	3
Type of plan/s for which received quote		B	4
Lowest quote per employee		B	4-8

Washington State Planning Grant on Access to Health Insurance

OVERVIEW OF ADMINISTRATIVE DATA SOURCES – Work in Progress

ADMINISTRATIVE (PROGRAM) DATA NEED	SOURCE	FREQUENCY OF DATA	STATUS	ISSUES	NOTES
PUBLIC PROGRAM DATA					
Medicaid	MAA database	Monthly	Data received	May need MAA guidance in interpretation of data.	Will break out Medicaid sub-programs and state-only subprograms
CHIP	MAA database	Monthly	Data received	May need MAA guidance in interpretation of data.	
Basic Health Plan (subsidized)	BHP Monthly Enrollment Reports	Monthly	Basic data received.		
Medicare	CMS Data on Quarterly enrollment	Monthly	Basic data received. Need to request enrollment by age/type of subprogram.	Medicare receipt may be coupled with other insurance e.g. employment-based.	Have started analysis of SPS to measure incidence of dual insurance.
PUBLIC EMPLOYEE INSURANCE					
Public Employees Benefits Board	PEBB monthly reports.	Monthly	Basic data received.	Dual coverage likely with Medicare.	Have requested breakdown of recipients by age.
Federal Employees Health Benefits Program (FEHBP)	Special data request.	Point in time.		Need to examine whether coverage overlaps with Medicare.	
TRICARE (Military)	Special data request.	Point in time.			
Public Schools (non-PEBB)				No centralized data source available. May need to be estimated using various sources.	Possible source for estimates: State Actuary data on self-insured government plans.

ADMINISTRATIVE (PROGRAM) DATA NEED	SOURCE	FREQUENCY OF DATA	STATUS	ISSUES	NOTES
Government (non-PEBB)				No centralized data source available. May need to be estimated using various sources.	Possible source for estimates: State Risk Manager and Superintendent of Schools for data on self-insured government plans.
INDIVIDUAL INSURANCE					
Enrollment in individual insurance through carriers	OIC, carriers	Sporadic.			Likely to need more recent data than 2000 to assess individual market.
Washington State Health Insurance Program (WSHIP-high risk pool)	WSHIP enrollment data	Monthly	Have sent data request to WSHIP.		Likely to need more recent data than 2000 to assess individual market.

Washington State Planning Grant on Access to Health Insurance
OVERVIEW OF SAFETY NET DATA SOURCES – Work in Progress

DATA AREA	SOURCE	FREQUENCY OF DATA	GEOGRAPHICAL AVAILABILITY	NOTES
Safety Net				
Location of CHCs/RHC's	Department of Social and Health Services, Medical Assistance Administration	Annual	List of Clinics (attributable by County)	Obtained list of FQHC/RHCs. Question: Is this a comprehensive list of CHCs? Are data available that describe other resources, i.e., community providers? Consider examining the relationship between numerical/geographic adequacy and provision of critical services given the scope, timing and resources available.
Community Health Services, Charity Care	Health Care Authority	Annual	List of Clinics (attributable by County)	Obtained list of HCA Funded Community Clinics.
Charity Care	CHARS Dataset, Department of Health, CHS.	Annual	Statewide	Need to understand payer categories, especially self pay vs. charity care. Consider what additional data may be informative at service-specific level. May also examine relationship between charity care/Medicaid revenue and services.
Safety Net admissions as a percent of total admissions, and as % of population under 200% FPL	RAND Market Characteristics Database	Annual	MSAs and rural counties in WA	Database is under construction, although summary statistics are available for 1990-1998. Variables that have 200 percent of poverty population as denominator are available at county level only.
Average hours of charity care, ambulatory settings.	RAND Market Characteristics Database	Annual	MSAs	Database is under construction, although summary statistics are available for 1990 to 1998.
Federal and local disproportionate share payments	Rutgers Safety Net Assessment	Annual?	County	Database is under construction, data depending on availability.

Washington State Planning Grant on Access to Health Insurance
OVERVIEW OF SAFETY NET DATA SOURCES – Work in Progress

DATA AREA	SOURCE	FREQUENCY OF DATA	GEOGRAPHICAL AVAILABILITY	NOTES
Access to Health Care				
Primary Care Health Professional Shortage Areas	Department of Health	Semi-Annual	Available by Health Service Areas.	Need to work with DOH to develop summary presentation of key findings and implications for access to care.
Survey data on access to primary care provider, doctor visits, etc.	Behavioral Risk Factor Surveillance System	Annual	Statewide. Some counties (e.g. King, Snohomish) sponsor enhanced samples to support local area estimates	While useful the survey is limited by the type of questions asked. Results do not include children. Potential questions to consider: Can we link survey questions to uninsured status? Geography? Other factors? Examine the following survey questions: When was your last check up? Do you have a personal doctor or clinic? Do you have a place you go to when sick or need advice?
Survey data on access to (primary care provider, doctor visits, etc.	National Survey of America's Families, Urban Institute	Semi-annual (1997 and 1999 thus far)	Statewide	Results for children only. Examine methodology and compare to BRFSS with the following questions in mind: Is there overlap and what are the inconsistencies between the two surveys?
HEDIS Data on immunizations, etc.	Medical Assistance Administration/ health plans	Annual	Available statewide for particular public plans (Medicaid, PEBB)	Need to identify sources- MAA? HCA? Health plans? Need to define what measures mean in terms of indicators of access.
Consumer Assessment of Health Plan Survey (CAHPS)	Medical Assistance Administration HCA?	Annual	Statewide	Results for Medicaid. Investigate whether information on other sources, such as health plans, is available and useful as indicator of access.

Washington State Planning Grant on Access to Health Insurance
OVERVIEW OF SAFETY NET DATA SOURCES – Work in Progress

DATA AREA	SOURCE	FREQUENCY OF DATA	GEOGRAPHICAL AVAILABILITY	NOTES
EPSDT Early and Periodic Screening Diagnosis and Treatment	Medical Assistance Administration	Annual	Available for Medicaid by plan and for FFS.	Results for Medicaid.
Potentially avoidable hospitalizations	DOH			Investigate measures and data sources for relevance.
Local plan adequacy	OIC, MAA, HCP.			Need to define what information is available and avoid overlap when defining adequacy. Question: How to interpret plan vs. community network adequacy? How to address overlapping networks?

Washington State Planning Grant on Access to Health Insurance

OVERVIEW OF OTHER DATA SOURCES - Work in Progress

Washington Health Resources Inventory: Key Indicators and Data Sources

Measures	Source	Time Period Available	Lowest Geo. Unit	Comments
Health Care Delivery System - National Data:				
HMOs:				
HMO Penetration Rates	Interstudy	Annual as of 1998	MSA	Proprietary data collected by Interstudy Decision Resources Inc. based on HMO surveys and regulatory data. "The Regional Market Analysis" also includes data on HMO costs and premiums. http://www.hmodata.com
HMO Competition Index	Interstudy	Annual as of 1998	MSA	Proprietary data collected by Interstudy Decision Resources Inc. based on HMO surveys and regulatory data. "The Competitive Edge Database" includes info for current year as well as 2 previous years and also has enrollment and utilization data. http://www.hmodata.com
Hospitals:				
# of Hospitals by Type	American Hospital Association	Annual	County	American Hospital Association compiles a large database based on their Annual Survey of Hospitals. It includes data on hospital capacity, organizational structure, community orientation, financial data, staffing, and other hospital services. http://www.aha.org
# of Systems and Hospitals	Rand	Annual	MSA	Proprietary data collected by Rand. Currently contains data from 1990-98, plus 1999 data for some variables.
Hospital Admissions and Total Days	American Hospital Association	Annual	County	See above.
Percent For-Profit Hospital Unit Admissions	Rand	Annual	MSA	See above.
Percent Non-Federal Government Hospital Unit Admissions	Rand	Annual	MSA	See above.

OVERVIEW OF OTHER DATA SOURCES - Work in Progress

Measures	Source	Time Period Available	Lowest Geo. Unit	Comments
Percent Non-Government, Non-Profit Hospital Unit Admissions	Rand	Annual	MSA	See above.
Hospital Beds by Services	American Hospital Association	Annual	County	See above.
Short Term Community Beds Hospital Unit Beds	Rand	Annual	MSA	See above.
# of Hospital Outpatient visits and Emergency Dept visits	American Hospital Association	Annual	County	See above.
Safety Net Admissions as a % of Total Admissions for Public and Teaching Hospitals	Rand	Annual	MSA	See above. Separate estimates for public and teaching hospitals are available.
Safety Net Admissions as a % of the Population below 200% Poverty for Public and Teaching Hospitals	Rand	Annual	MSA	See above. Separate estimates for public and teaching hospitals are available.
ER and Outpatient Use in Safety Net Hospitals Below 200% of Poverty for Public and Teaching Hospitals	Rand	Annual	MSA	See above. Separate estimates for public and teaching hospitals are available.
Average Hours of Charity Care--Ambulatory	Rand	Annual	MSA	See above.

Physicians:

# of Physicians	ARF	Annual	County	The Area Resource File contains over 7,000 health resources variables for each county, drawing from over 50 primary data sources. Domains covered include health professions, health facilities, hospital utilization, hospital expenditures, Medicare enrollments and reimbursements, population characteristics and economic data, environment, and health professions training. http://www.arfsys.com

Washington State Planning Grant on Access to Health Insurance

OVERVIEW OF OTHER DATA SOURCES - Work in Progress

Measures	Source	Time Period Available	Lowest Geo. Unit	Comments
Average physicians per practice	Rand	Annual	MSA	See above.
Average hours direct patient care by physicians	Rand	Annual	MSA	See above.
Average % physician revenue from largest contract	Rand	Annual	MSA	See above.
Average % revenue physician from managed care	Rand	Annual	MSA	See above.
HRSA local and community grants to expand access (CHC, CAP, other)	HRSA	2001	County	http://www.hrsa.gov

Health Care Delivery System - State Data:

Primary care providers in Shortage Areas (FTEs, low income %, whether accepting new patients)	WA Health Professional Shortage Surveys	3-year cycle	County	Voluntarily conducted by counties. Not consistently collected across state.
# of Licensed physicians in state (including retirees and state administrators)	WA DOH Licensing Database	Annual	Zip Code	Overstates providers.
# of Health Professionals (MDs, naturopathic physicians, nurse practitioners, physician assistants, dentists, dental hygenists, pharmacits, registered nurses and LPNs)	WA Health Professional Licensing Survey	1998/1999	Health service areas	Survey discontinued. Only available for 1998/1999.
Health Professionals by specialty, FTEs, accepting Medicaid, capacity for low-income	WA Health Professional Licensing Survey	1998/1999	Zip Code	Survey discontinued. Only available for 1998/1999.

Washington State Planning Grant on Access to Health Insurance

OVERVIEW OF OTHER DATA SOURCES - Work in Progress

Measures	Source	Time Period Available	Lowest Geo. Unit	Comments
# of Rural health clinics	WA Medical Assistance Administration	NA	Zip Code	Not available on a regular schedule.
# of Federally Qualified Health Clinics	WA Medical Assistance Administration	NA	Zip Code	Not available on a regular schedule.
Medicaid providers (# of PCPs)	Integrated Provider Network Database	Annual	NA	This database contains primary care providers for the Basic Health, Children's Health Insurance Program (CHIP), Healthy Options, and Public Employees Benefits Board (PEBB) plans. https://wws2.wa.gov/dshs/maa/ipndweb/
Local Disproportionate Share Hospital (DSH) Payments by Hospital	WA Disproportionate Share Provider Study,	2000	State	Conducted by WA Medical Assistance Administration, Department of Social and Health Services. Data reported from the Hospital Reimbursement Section of MAA.

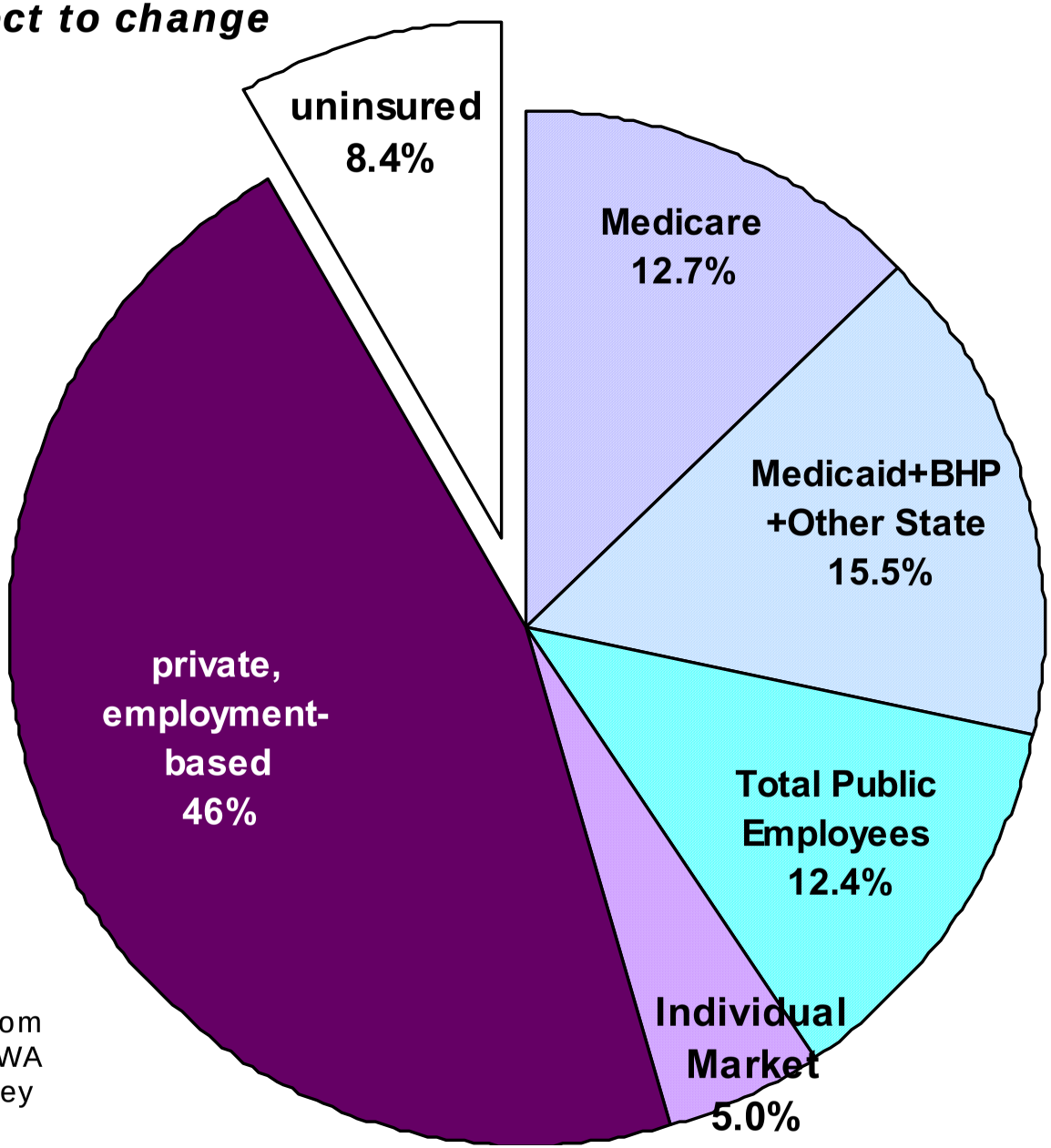
Utilization of WA health clinics

# of Enrollees by Medicaid Provider	Integrated Provider Network Database	Annual	NA	See above.
Average Travel Distance to Medicaid Provider	Integrated Provider Network Database	Annual	Town	See above.

Sources of Insurance (And Uninsured), Washington State, 2000

DRAFT – Subject to change

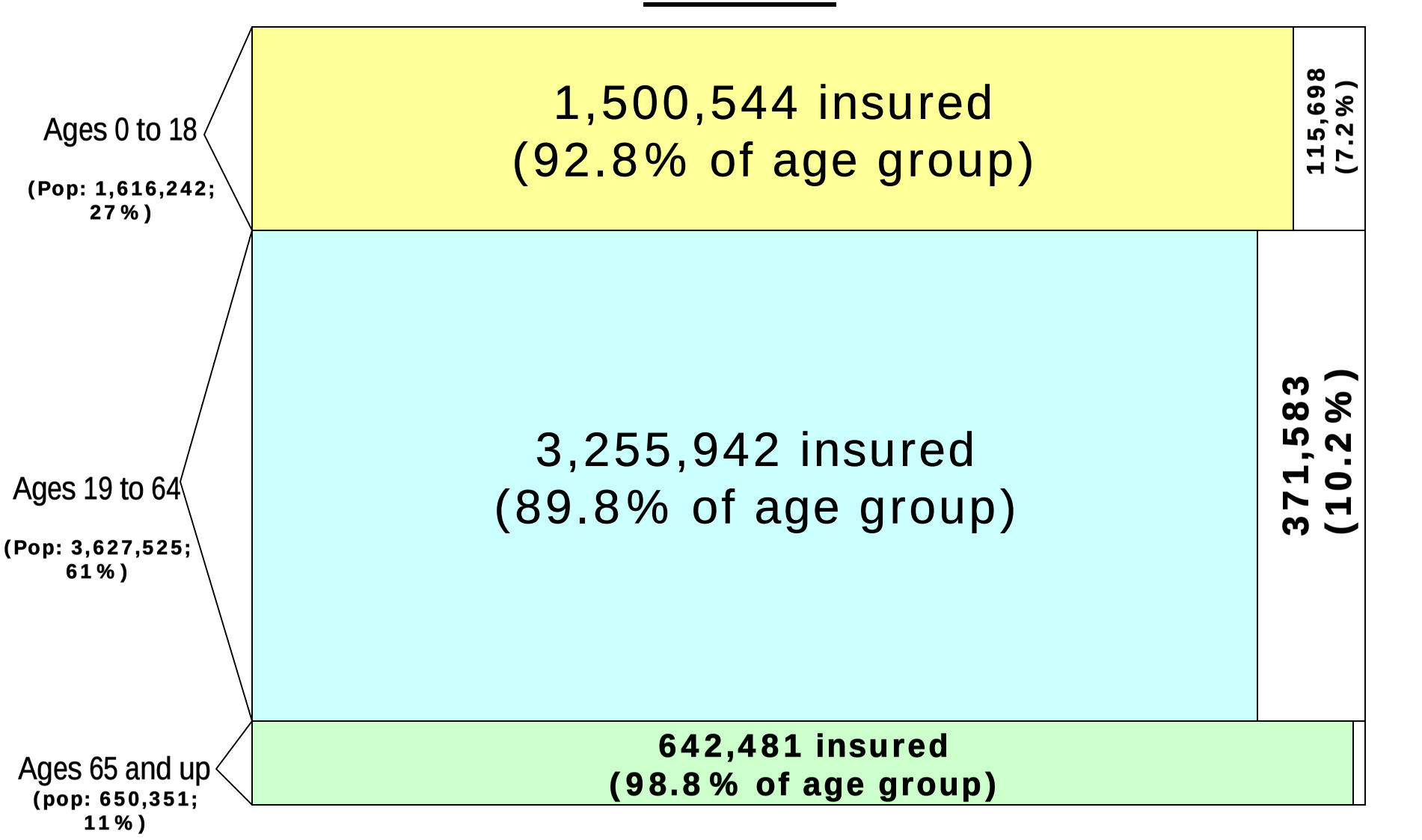
Note: Preliminary analysis, some percentages are estimates.



HPAP Analysis using administrative data from various sources, and WA State Population Survey

Insured and Uninsured in Washington State, 2000, by Age

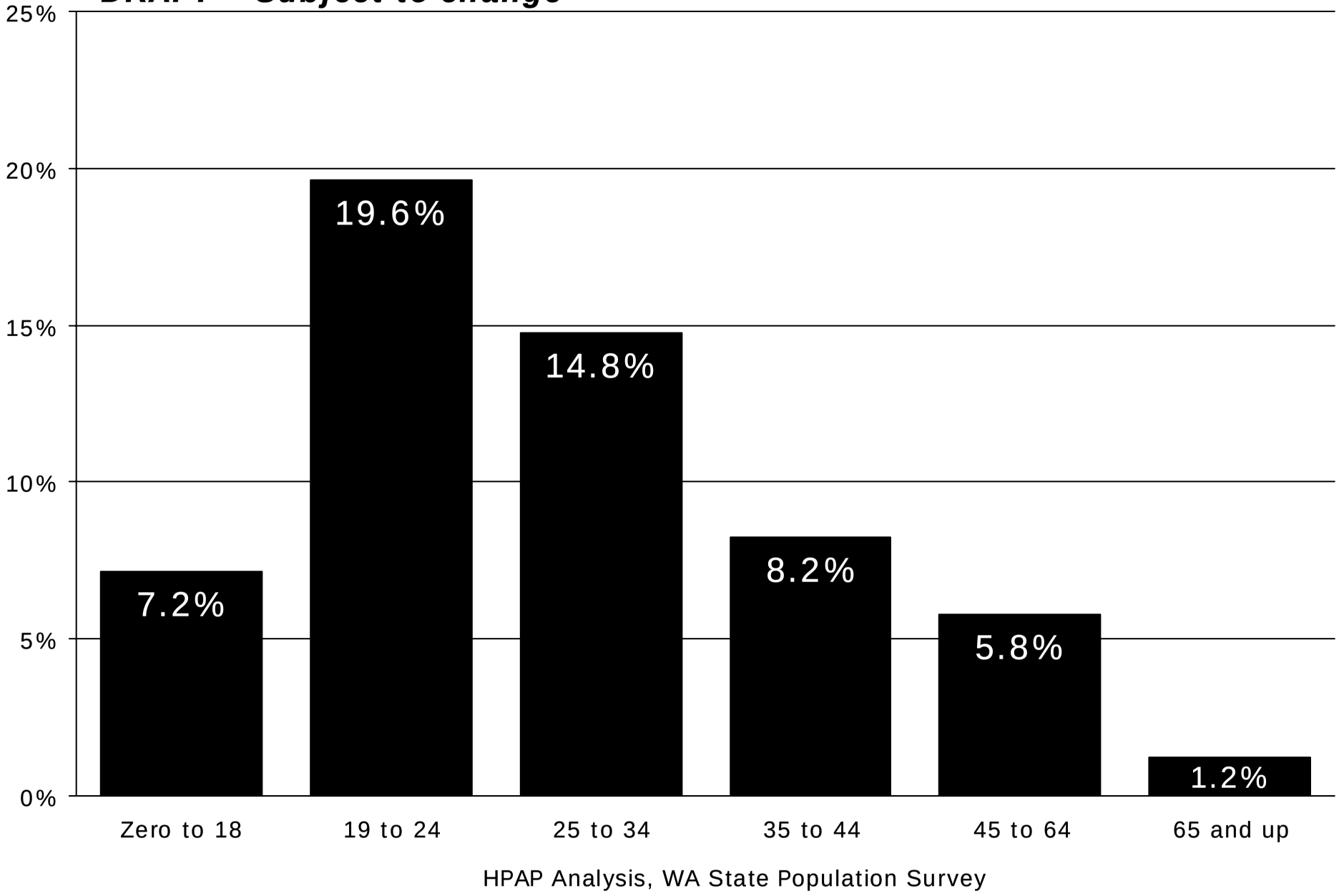
DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Percent Uninsured by Age Group, Washington State, 2000

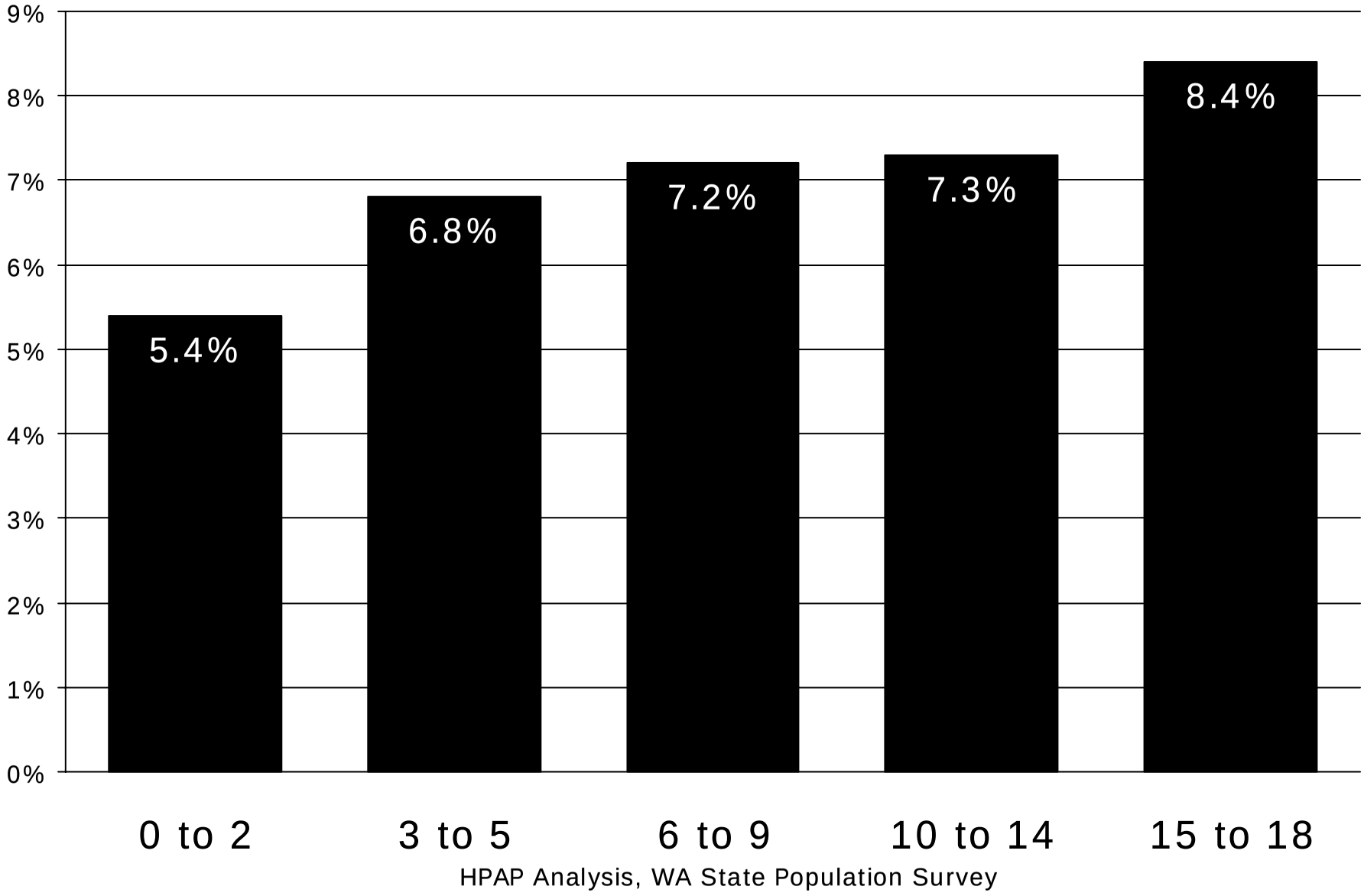
DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Percent of Uninsured Children Ages 0 to 18 by Age Group, Washington State, 2000

DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Uninsured Rates by Household Income Category, 2000

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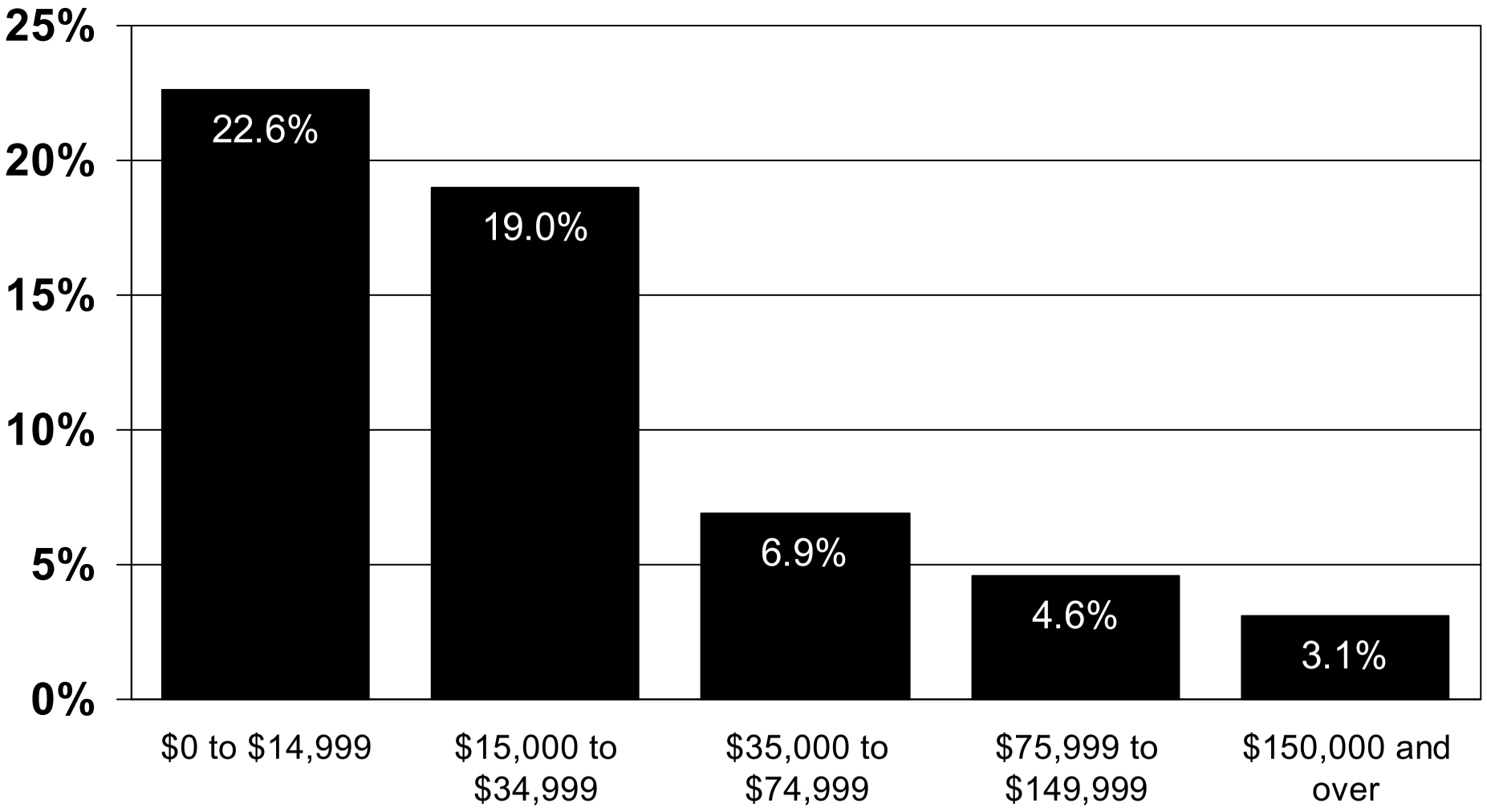
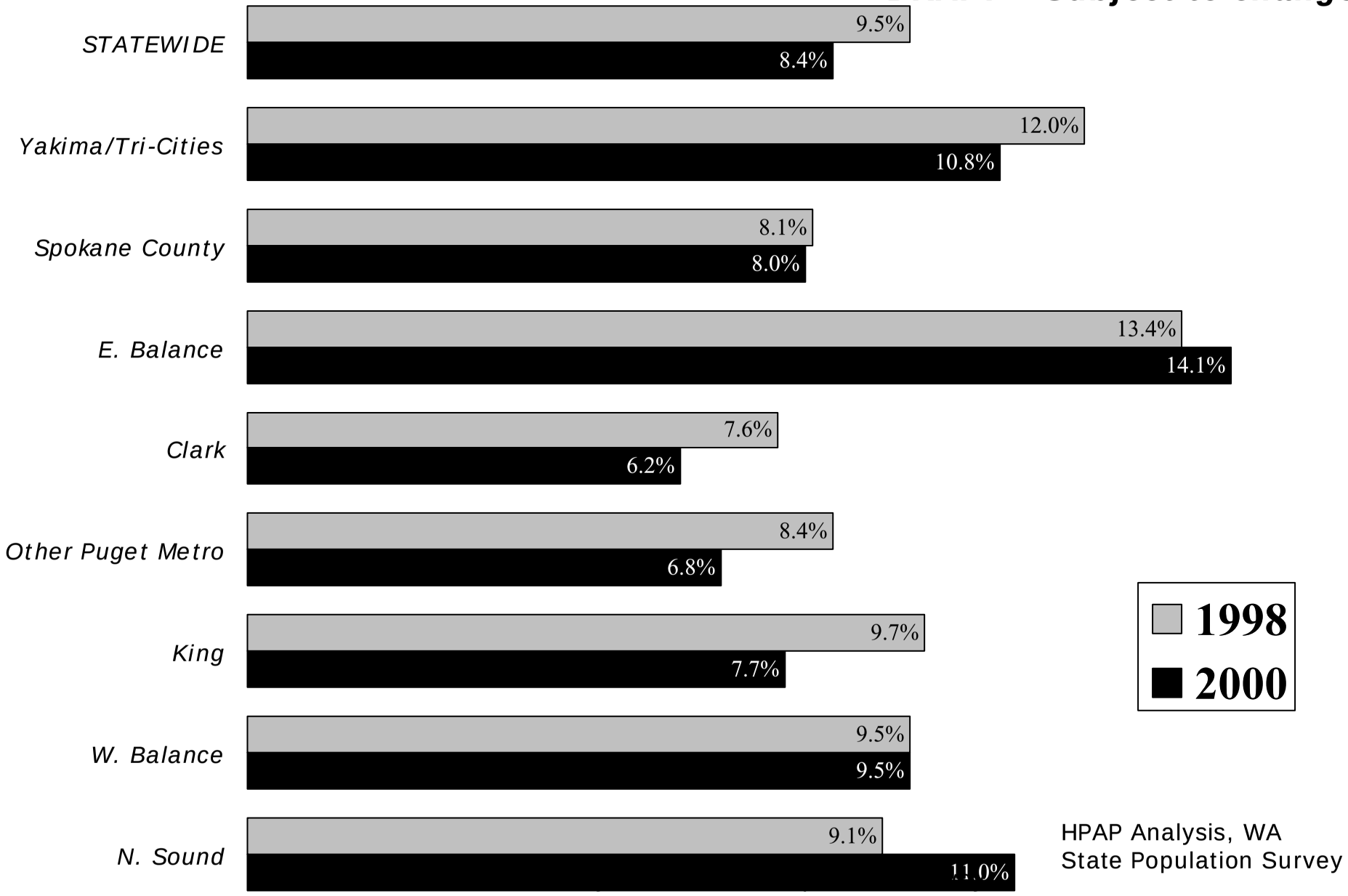


HPAP Analysis, WA State Population Survey

Washington State Population Survey, Rates of Uninsured by Region, 1998 and 2000, All Ages

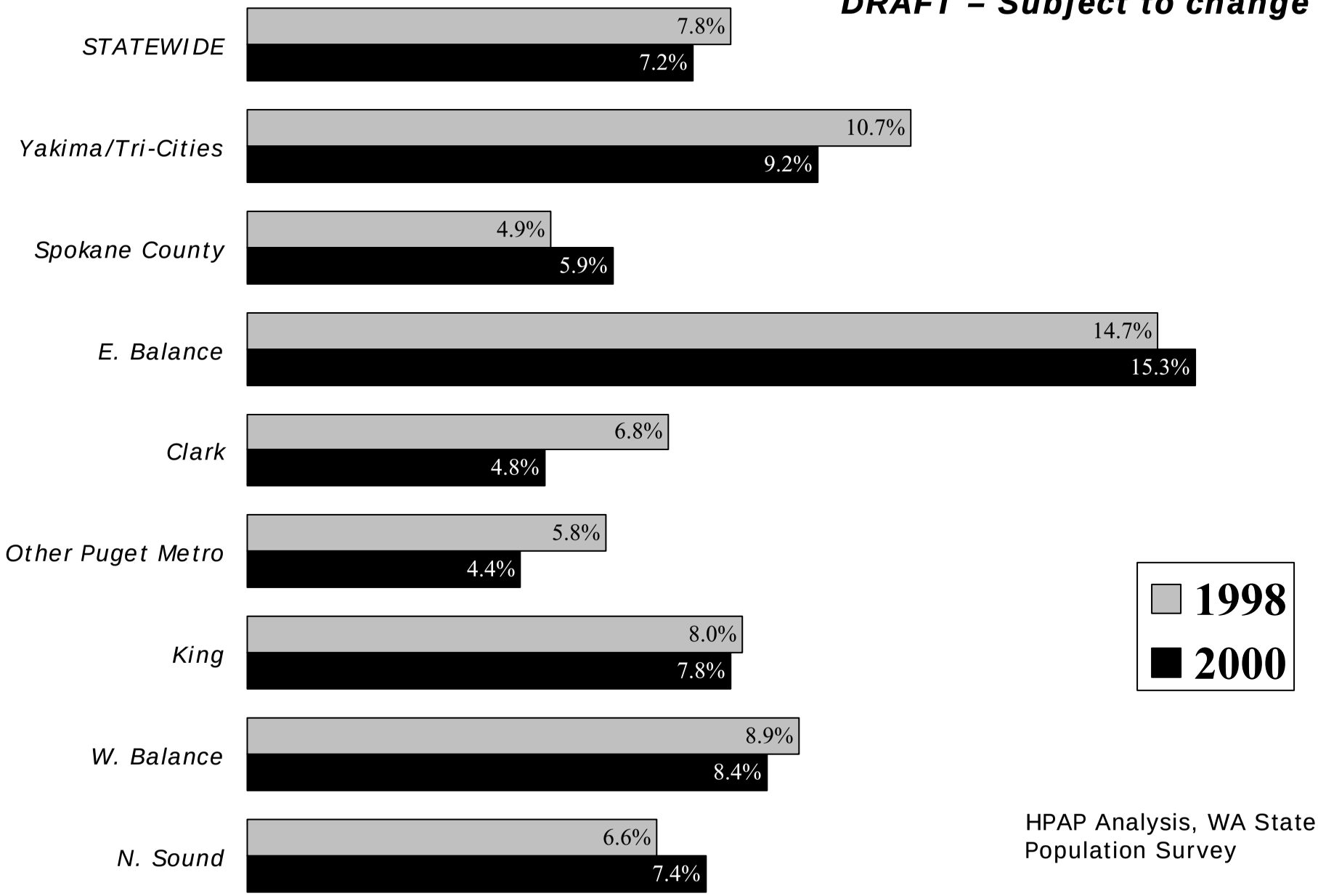
DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Washington State Population Survey, Rates of Uninsured by Region, 1998 and 2000, Ages 18 and Under

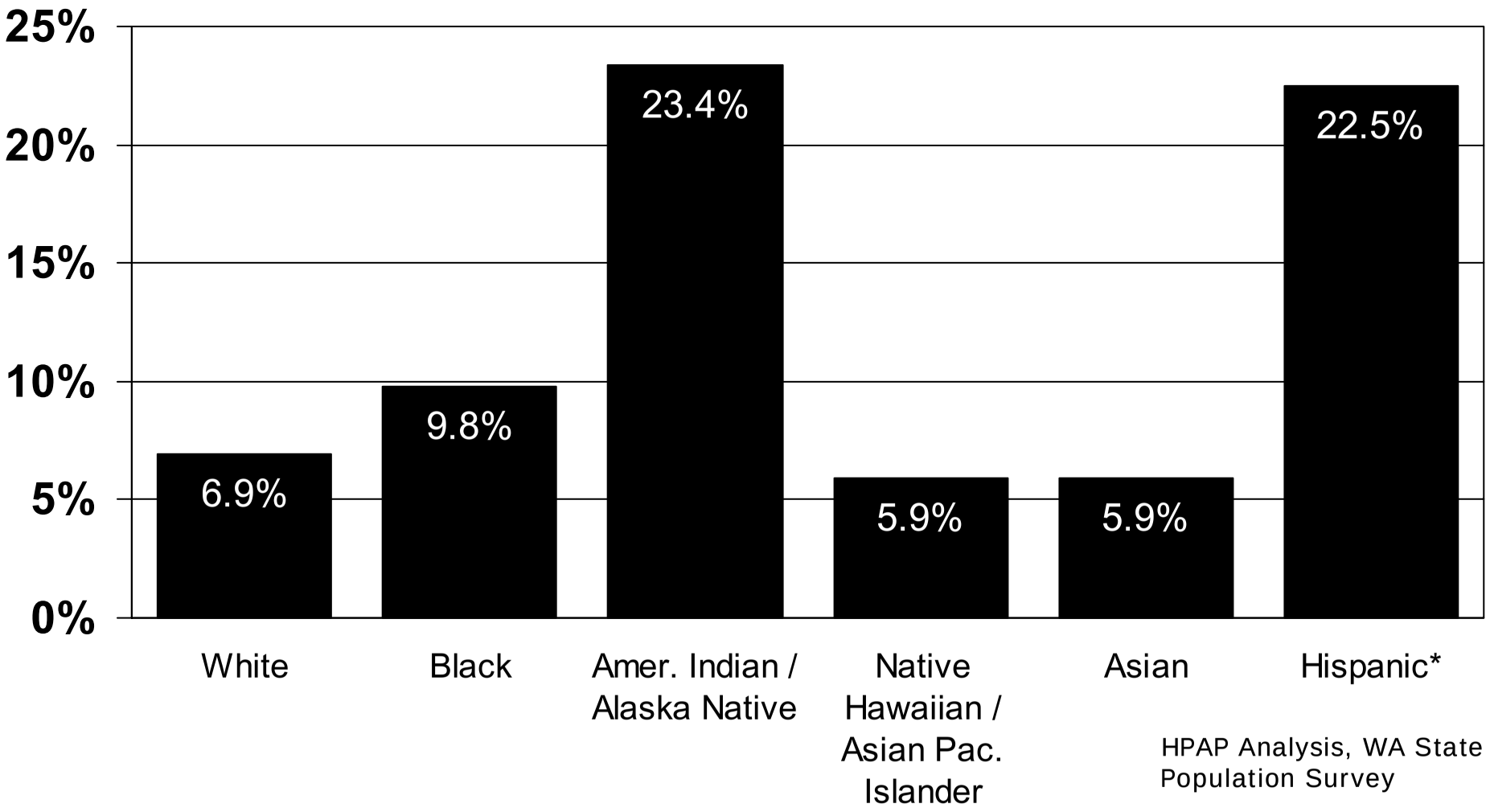
DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Uninsured Rates by Race/Ethnicity, 2000

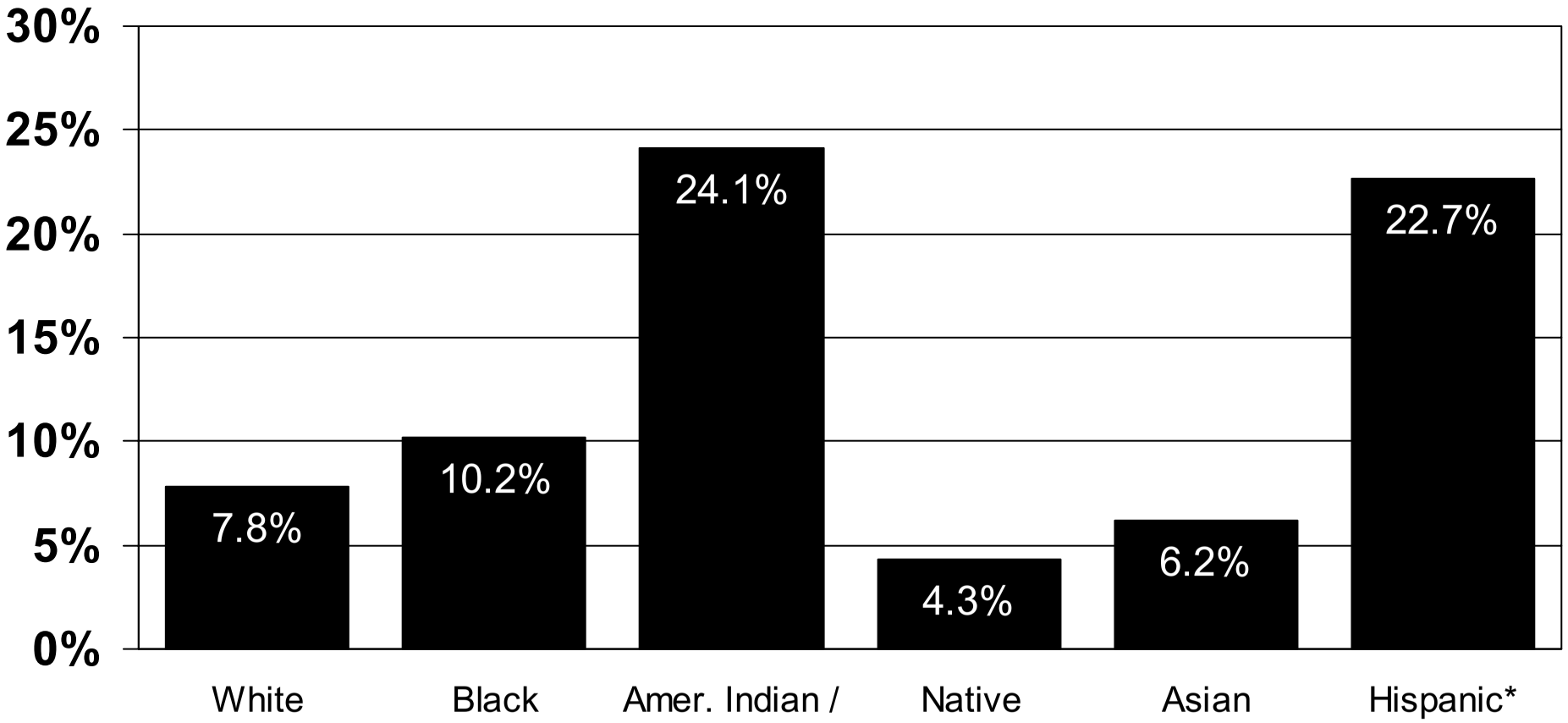
DRAFT – Subject to change



* Hispanics can be of any race. Hispanics are not counted in the race categories presented here.

Uninsured Rates by Race/Ethnicity, Under 65, 2000

DRAFT – Subject to change

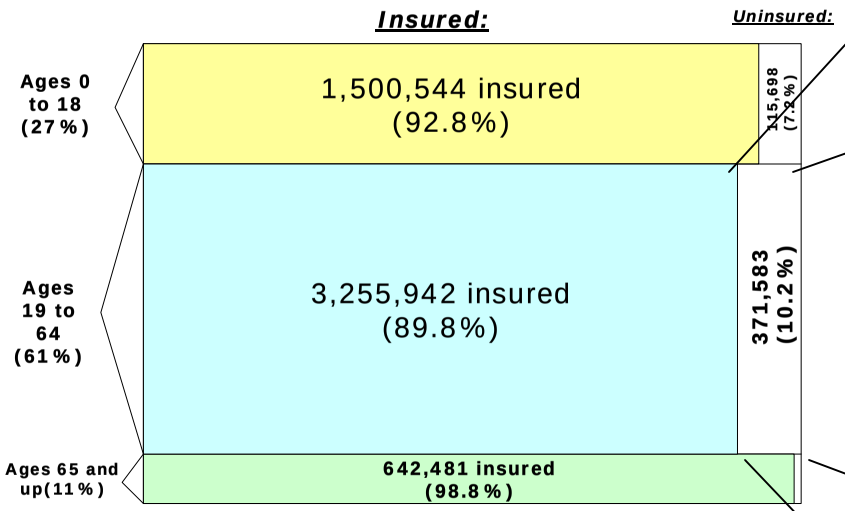


* Hispanics can be of any race. Hispanics are not counted in the race categories presented here.

HPAP Analysis, WA State Population Survey

Race and Ethnicity of Uninsured Adults

DRAFT – Subject to change



percent distribution:

White	68.3%
Black	4.7%
Amer. Indian / Alaska Native	6.0%
Native Hawaiian or Other API	0.2%
Asian	3.7%
Hispanic	17.2%

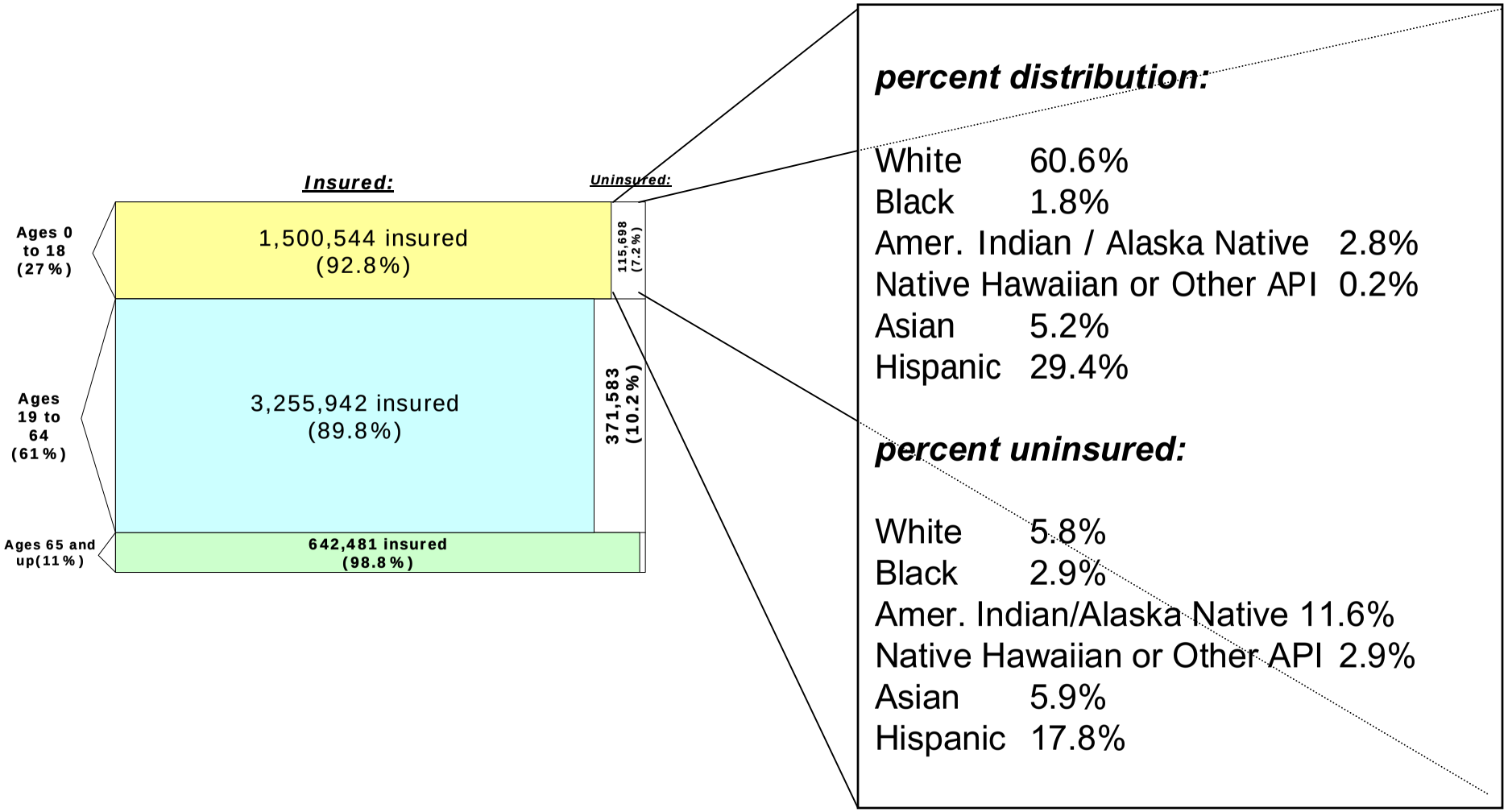
percent uninsured:

White	8.6%
Black	14.6%
Amer. Indian/Alaska Native	28.7%
Native Hawaiian or Other API	5.0%
Asian	6.3%
Hispanic	26.5%

HPAP Analysis, WA State Population Survey

Race and Ethnicity of Uninsured Children

DRAFT – Subject to change



HPAP Analysis, WA State Population Survey

Washington State Planning Grant on Access to Health Insurance
Private Payer Questionnaire

Name of Payer: _____ Contact Person: _____ Title of Contact: _____

Telephone Number: _____ Fax Number: _____ Email Address: _____

1. Please provide the following information about your private clientele in the State of Washington.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual Products	Small Group Products	Large Group Products		Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured			Insured	Self-Insured
Number of private benefit packages or plan designs								
Number of plan sponsors[1]	N/A				N/A			
Number of subscribers								
Covered members								
▪ With no other insurance								
▪ With other insurance								
▪ Total								
Names of largest private benefit package/plan sponsors	N/A				N/A			

[1] *E.g., private employers.*

2. On what basis does your organization define a "plan" or "product" as separate from other plans or products? (*Please check all applicable responses.*)
   - ☐ Unique benefit package
   - ☐ Separate plan sponsor(s)
   - ☐ Specific other features (e.g., access to restrictive provider networks in certain locations)
   - ☐ Other (*Please specify.*)

   _____

   _____

   _____

3. What mechanisms does your organization use to identify different private plans? (*Please check all applicable responses.*)
   - ☐ Unique plan identifiers (ID codes)
   - ☐ Separate contracts
   - ☐ Dedicated account representatives or teams
   - ☐ Other (*Please specify.*)

   _____

   _____

   _____

4. What services are generally not included as covered benefits in private products? (*Please check all applicable responses.*)

Services Generally Not Covered (Excluded)	Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured
Basic vision benefits				
Care provided by relatives or household members				
Care that is the responsibility of another party, or covered under workers compensation				
Governmental services or services covered by (other) governmental plans				
Cosmetic services				
Dental care				
Experimental services				
Infertility-related care				
Private nursing				
Rental or purchase of luxury durable medical equipment				
Special education				
Other (*Please specify.*)				

5. Please show the most common <u>non-prescription drug</u> benefit features included in your private plans:

	Individual Products			Small Group Products			Large Group Products					
							Insured			Self-Insured		
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Deductibles												
▪ Per individual	$	$	$	$	$	$	$	$	$	$	$	$
▪ Per family	$	$	$	$	$	$	$	$	$	$	$	$
Coinsurance levels	%	%	%	%	%	%	%	%	%	%	%	%

	Individual Products			Small Group Products			Large Group Products					
							Insured			Self-Insured		
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Copays												
▪ Office visit	$	$	$	$	$	$	$	$	$	$	$	$
▪ Hospital admission	$	$	$	$	$	$	$	$	$	$	$	$
▪ Other non-drug (*Please specify.)*	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
Internal plan limits on days, visits, procedures, dollars or other												
▪ Mental health care	$	$	$	$	$	$	$	$	$	$	$	$
▪ Chemical dependency care	$	$	$	$	$	$	$	$	$	$	$	$
▪ Home health care	$	$	$	$	$	$	$	$	$	$	$	$
▪ Skilled nursing facility care	$	$	$	$	$	$	$	$	$	$	$	$
▪ Rehabilitation services	$	$	$	$	$	$	$	$	$	$	$	$
▪ Other non-drug (*Please specify.)*	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
Plan maximums (per lifetime)	$	$	$	$	$	$	$	$	$	$	$	$
Annual out-of-pocket limits												
▪ Per individual	$	$	$	$	$	$	$	$	$	$	$	$
▪ Per family	$	$	$	$	$	$	$	$	$	$	$	$

6. What are your most frequent prescription drug cost-sharing approaches in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Five most common cost-sharing arrangements (indicate brand vs. generic; formulary vs. non-formulary)								
▪ First								
▪ Second								
▪ Third								
▪ Fourth								
▪ Fifth								

7. What are your most frequent in- and out-of-network benefit differentials in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
A. Five most common coinsurance arrangements (*e.g., 90%/70%*)	*e.g., 90%*	*e.g., 70%*						
– First								
– Second								
– Third								
– Fourth								
– Fifth								

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
B. Five most common copay arrangements (e.g., $10/$25)	*e.g., $10*	*e.g., $25*						
– First								
– Second								
– Third								
– Fourth								
– Fifth								

8. Please outline your primary gatekeeper (utilization management) requirements, and the types of benefits affected. (*Please check all applicable items.*)

Private Plans	Individual Products ***e.g., mandatory pre-admission certification***	Small Group Products	Large Group Products	
			Insured	Self-Insured ***e.g., voluntary case management***
Hospitalization				
Selected diagnosis				
Selected treatment				
Non-formulary				
Other (*Please specify.*)				

9. With regard to your private group plans, please provide your minimum underwriting rules for insured groups.

Private Plans	Small Group (Insured)	Large Group (Insured)
Minimum number of hours employees must work to qualify for coverage	_____ hours per week	_____ hours per week
Minimum employer contribution toward employee coverage	_____ %	_____ %
Minimum employer contribution toward dependent coverage	_____ %	_____ %
Other (please summarize)		

10. What, if any are the major distinguishing features of private plans you offer in different parts of Washington?

Private Plans	Individual	Small Group	Large Group	
			Insured	Self-Insured
Northwest Washington				
Seattle Area				
Southwest Washington				
Northeast Washington				
Spokane Area				
Southeast Washington				

11. From your organization's perspective, what are the reasons certain features, and variations among them, become commonplace or unusual? (*1=most important reason, 2=second most important reason, etc.*)

- Insurance mandates _____
- Marketplace demands _____
- Ease in administration _____
- Ease in communicating _____
- Other (*Please specify.*) _____
  - _____
  - _____

We ask that you please forward the following with your completed questionnaire no later than November 16, 2001 to:

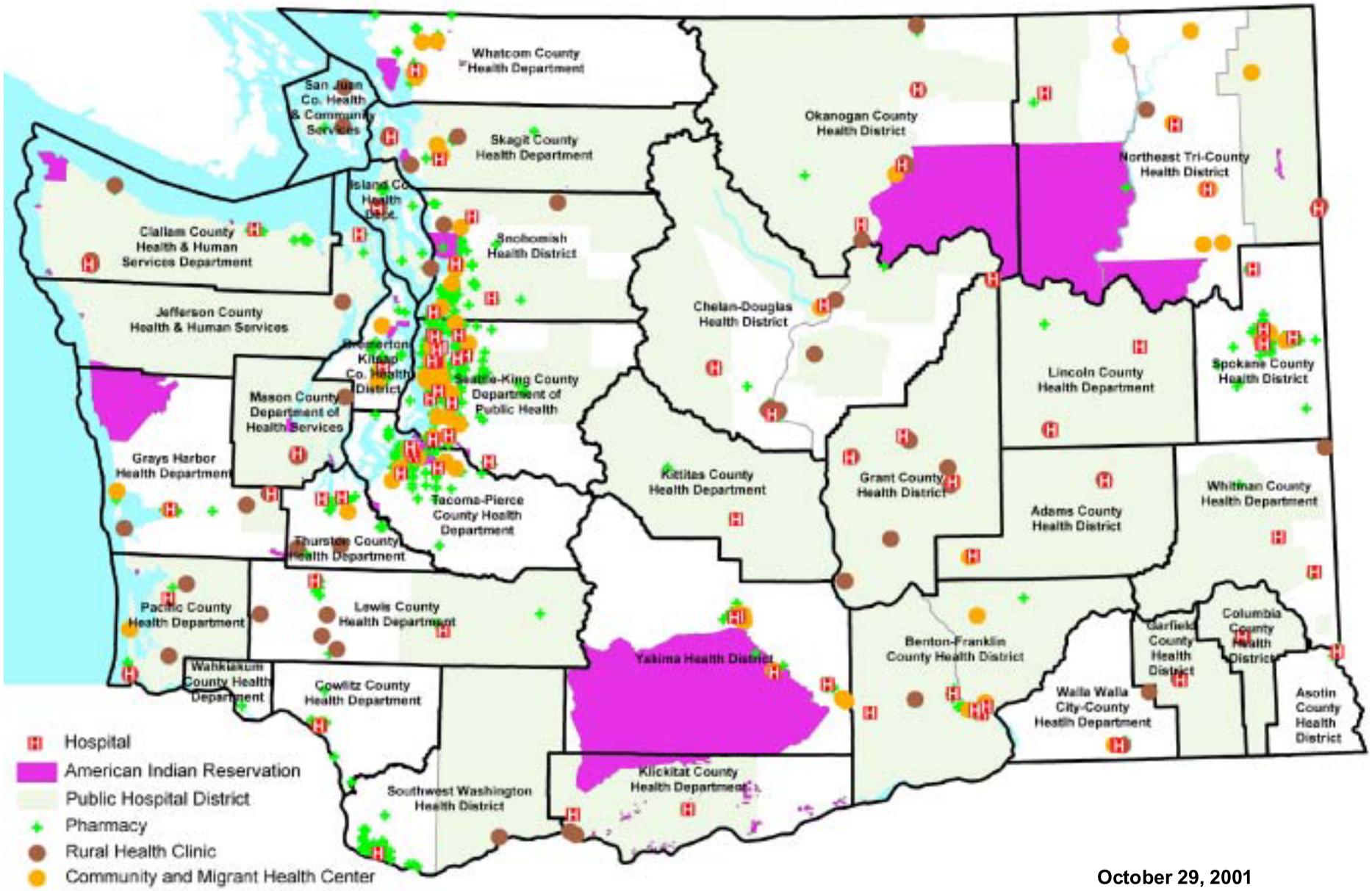
Florence Katz
William M. Mercer, Incorporated
600 University Street, Suite 3200
Seattle, WA 98101

- Sample plan element worksheet (listing of benefits) used by your underwriters and actuaries to price plans.
- Sample plan implementation worksheets used to define or program adjudication rules (both manual and automatic).
- A rate sheet and associated benefit summary for your *individual* market plan:
  - Of highest benefit value with significant enrollment
  - With the highest enrollment
  - Of lowest benefit value with significant enrollment.
- A rate sheet and associated benefit summary for your *small group* market plan:
  - Of highest benefit value with significant enrollment
  - With the highest enrollment
  - Of lowest benefit value with significant enrollment.

Thank you for your cooperation. If you have any questions, please contact Florence Katz at 206 808 8469 or florence.katz@us.wmmercer.com.

Washington State Planning Grant on Access to Health Insurance

HEALTH CARE SAFETY NET SITES – Work in Progress



October 29, 2001

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ADMINISTRATIVE SIMPLIFICATION – INTERVIEW PROTOCOL FOR INITIAL INVENTORY OF EFFORTS

1. Name of interviewee
2. Title and workplace
3. Organization re: Administrative Simplification
4. Role in Organization
5. Recommended alternative/additional contacts:
6. Identification of the administrative simplification initiative (Name or label to which it is referred)
7. Description of initiative
8. Other initiatives under discussion/needed/considered
9. Leader/lead organization
10. Participants in the initiative
11. Location or locations of the initiative (single site, multiple sites)
12. Time Frame of initiative
13. Problem initiative is designed to address
14. Expected impact
    a. Savings of time
    b. Savings of money
    c. Reduce duplication of resource use
    d. Overall return on investment
    e. Examples:
15. Intended assessment of the initiative
    a. Anecdotal
    b. Evidence-based
    c. By whom
        i. In-house
        ii. Outside
        iii. Formal
16. Barriers/constraints
    a. Government
        i. State
        ii. Federal
        iii. Other
    b. System-wide barriers
        i. Administrative infrastructure
    c. Money
17. State government role
    a. Current
    b. Potential
18. Follow-up opportunities
    a. Primary point of contact
    b. Meetings/forum
19. Overlaps with other initiatives
20. Category of administrative simplification – to be created from the results of the inventor
21. Source of information regarding the initiative

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COMMUNITY INITIATIVES: INTERVIEW PROTOCOL FOR INITIAL INVENTORY OF EFFORTS – Work in Progress

1. Community Access Initiative
2. Lead Organization(s)
3. Scope of Initiative (geographic, subpopulation, etc.)
4. Major components of initiative (description of)
5. Purpose(s) and/or Expected Outcomes
6. Source of Information (i.e., interviewee, meeting participants)
7. State Roles(s) if any
8. Types or Areas of Technical Assistance or Partnership Sought by Communities
9. Administrative, Regulatory, or Legislative Changes or Flexibility That Might Support Community Access Initiatives
10. Types of Assistance Communities Would Seek From the State
11. Barriers to State Partnership Perceived by Communities

Washington State Planning Grant on Access to Health Insurance
Work in Progress

GUIDING PRINCIPLES

These guiding principles provide context for work conducted under the auspices of the state planning grant on access to health insurance. The bullets are not in any priority order.

In our approach to "doing the work of" the grant we are committed to:

- Seeking input and feedback in a low key but broadly inclusive manner
- Not advocating for any single approach
- Informing discussions through solid data and analysis
- Maintaining faith that there are good ideas yet to come
- Keeping expectations of the grant realistic – one step forward is one step better than nothing
- Doing work that is relevant for today's and tomorrow's circumstances
- Building on, being complementary to, and supporting efforts of others to address related issues
- Focusing our expertise and resources where they can be of greatest value
- Being informed and inspired by the experience and lessons of previous efforts
- Moving beyond "admiring" the problem

In researching options to address access, we are interested in ideas that:

- Include local / community control and accountability
- Seek to expand private/public partnerships
- Reduce existing system complexities
- Are incremental and focused, preferably within a context of longer-range solutions
- Maintain consumer protections and choice but allow for regulatory or statutory simplification
- Are voluntary and incentive-based
- Target specific barriers and gaps faced by specific groups
- Refocus, redirect, and maximize existing delivery and financial resources
- Retain valued aspects of the current delivery and financing systems
- Challenge historical and existing assumptions about programs and systems
- Assist in maintaining Washington's gains of the past

MAKING HEALTH CARE WORK FOR EVERYONE

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

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Overview of Strategy for Seeking Input and Feedback

- The grant seeks to be broadly inclusive, while maintaining a targeted low-key approach

- Research work/findings will be shared broadly for review and input from interested parties

Summary of approaches:

The grant project will seek broad input and feedback on grant products through:

1. Web-based alerts with periodic updates and notification of NEW items available for review and feedback

2. Large stakeholder meetings:
   a. December 4, 2001 – Panel at the 2001 Washington Health Legislative Conference
   b. Regional meetings for feedback on draft products of grant and identification of recommendations for policy consideration

3. Targeted technical assistance or directional input from:
   a. Individuals with technical knowledge
   b. Small groups with specialized knowledge or concerns
   c. A Management Oversight Panel
   d. The Governor's Sub-Cabinet on Health

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WHO'S WHO

Management Oversight Panel and Governor's Sub-Cabinet on Health include representatives from:

- Department of Health
- Department of Social and Health Services – Medical Assistance Administration
- Health Care Authority
- Office of Financial Management
- Office of Insurance Commissioner
- State Board of Health

Stakeholders represent a broad range of organizations potentially interested in health care issues, including:

Aetna Inc.
Alaska Air Group
American Indian Health Commission
Association of Washington Business
Association of Washington Cities
Association of Washington Healthcare Plans
Basic Health Advisory Committee
Boeing
Center for Medicaid and Medicare Services
Children's Alliance
CHOICE Regional Health Network
Columbia Legal Services
Community Choice PHCO: Provider Network
Community Health Plan of Washington
Deborah E. Peterman & Associates, Inc
Department of Corrections
Department of Health
Department of Labor & Industries
Department of Social & Health Services
Department of Veterans Affairs
Economic Opportunity Institute
Employer's Health Purchasing Co-op
Everett Clinic
Friends of Basic Health
Foundation for Health Care Quality
Group Health Cooperative of Puget Sound
Health Care Authority
Health Improvement Partnership
Health Insurance Association of America

Health Resources & Services Administration
Human Links
IDX Systems Corporation
Immunex Corporation
Jamestown S'Klallam Tribe
Jefferson County Critical Access Project
Kaiser Foundation Health Plan of the Northwest
King County Health Action Plan
KMS Financial Services
Medical Assistance Administration
Molina Healthcare of Washington, Inc.
National Federation of Independent Business
NEWMG/Colville Medical Center
Nordstroms, Inc
Noridian Government Services
Northwest Portland Area Indian Health Board
Office of Financial Management
Office of the Attorney General
Office of the Insurance Commissioner
PACCAR, Inc.
PacifiCare of Washington
Pike Market Medical Clinic
Pointshare
Premera Blue Cross
Providence Health Systems
PROWest
RAND Corporation
Regence BlueShield
Rutgers University
Seattle Indian Health Board
Seattle King County Department of Public Health
State Board of Health
Swedish Health Services
The Healthcare Decisions Group, LLC
University of Washington
Washington Association of Churches
Washington Association of Community and Migrant Health Centers
Washington Association of Counties
Washington Association of Health Underwriters
Washington Citizen Action
Washington Education Association
Washington Federation of State Employees
Washington Health Care Association
Washington Health Foundation
Washington Independent Business Association

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Washington Policy Center
Washington Public Employees Association
Washington Rural Health Association
Washington State Congressional Delegation
Washington State Dental Association
Washington State Hospital Association
Washington State Labor Council
Washington State Legislature
Washington State Medical Association
Washington State Nurses Association
Weyerhauser Company
William Meacham Insurance
William Mercer Inc.
WWAMI Center for Health Workforce Studies
Yakima Valley Farm Workers Clinic

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